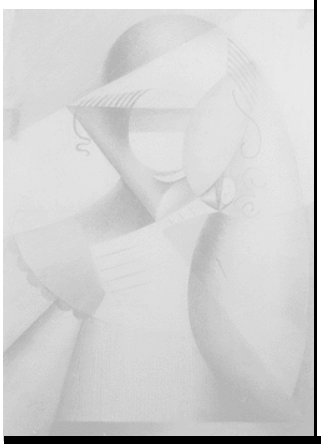

# Perinatal Domestic Violence Identification Services

April, 2004

A GUIDE TOWARD CULTURALLY RELEVANT CARE IN HEALTH CLINICS

Washington State Department of Health

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration
Maternal and Child Health Bureau

# Perinatal Domestic Violence Identification Services

## A Guide Toward Culturally Relevant Care in Health Clinics

April 2004

This guide is the result of a three-year Health Resources and Services Administration, Maternal Child Health Bureau demonstration grant (CFDA: 93-926J). The funding supported a project implemented at the International Community Health Services (ICHS) prenatal clinic, which serves Asian and Pacific Islanders (API) in Seattle, Washington. The project was designed to increase culturally relevant screening and intervention rates. This guide reflects the lessons learned from the Project experience.

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# Acknowledgements

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This guide was the result of a three-year demonstration project that developed into a case study of how a community clinic with high diversity adapts a mainstream domestic violence identification system of care toward greater cultural relevance for women and infants who experience violence.

The case study took place at the International Community Health Services (ICHS) clinic in Seattle, Washington from July 2000 to March 2003. The project staff, ICHS clinical staff and administration devoted considerable time to this case study. Their experiences from this effort are the core of this guide.

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# Appendices

# I. Executive Summary

National statistics indicate that one third of U.S. women will be physically abused by a current or former partner during their lifetime (Common Wealth Fund, 1999). A Centers for Disease Control (CDC) study that reviewed the research literature on the prevalence of domestic violence during pregnancy found that pregnant women reported experiencing domestic violence during pregnancy between .9% and 20% with the majority of studies ranging between 4% to 8% (Gazmariaian, 1999). Studies indicate that women who experience physical abuse during pregnancy are at higher risk for miscarriages and low birth weight babies (Bullock, 1989).

Universal screening for domestic violence during pregnancy is a recommended practice by the American College of Obstetricians and Gynecologists, American College of Nurse Midwives, the American Medical Association and the American Nursing Association.

It is important to note that routine screening is standard practice in all prenatal care protocols for pre-eclampsia or gestational diabetes. These conditions occur in less than 7% of pregnant women. Yet, there is no routine screening for domestic violence during pregnancy.

This guide is focused on providing community health clinic administrators with methods to develop a culturally relevant clinic response to domestic violence experienced by pregnant/postpartum patients. The guide provides:

1. A rationale for developing identification systems during pregnancy and postpartum.

2. An eleven-question assessment tool.

3. A strategy for developing a targeted plan for quality assurance.

4. Sample activities, tools, protocols and training materials.

5. A list of state and national resources.

This guide acknowledges the challenges of domestic violence identification activities and the demands placed on community health clinics. The material provided is based on the experiences of the Perinatal Partnership Against Domestic Violence (PPADV) International Community Health Services (ICHS) Domestic Violence Project (PPADV – ICHS Domestic Violence Project) funded by Health Resources and Services Administration (HRSA) Maternal Child Health (MCH) Grant.

# II. Introduction

## A. Purpose of This Guide

Effective prenatal/postpartum care includes identification of all forms of domestic violence and providing effective culturally relevant interventions. The purpose of this guide is to provide community clinics serving diverse populations with processes to develop, refine and increase assistance for patients experiencing domestic violence during pregnancy. Most community clinics have some system of domestic violence screening and intervention for pregnant patients based on mainstream protocols, screening guides and tool kits. This guide is not a cookie cutter method of developing strategies; it provides a set of processes that can increase culturally relevant service. It is designed to:

1. Identify strengths and barriers in the current clinic procedures in relation to the population served;

2. Provide processes to assess and plan targeted activities that will increase safety and culturally relevant interventions, and

3. Provide sample tools and materials that can be adapted for use.

The items in this guide will allow clinics to assess their current practices in relation to pregnant post-partum patients experiencing domestic violence, establish a long-term targeted plan to increase culturally relevant practices and evaluate progress.

## B. Definitions

### Patients

For the purposes of this manual the term "patients" will refer to pregnant/postpartum women who are served by the clinic.

### Domestic Violence

Definitions of domestic violence will vary. For the purposes of this manual the following definition is:

> "*Domestic violence is a* ***pattern*** *of assaultive and coercive behaviors, including* ***physical, sexual and/or psychological attacks*** *as well as economic coercion and use of immigrant/ refugee status that adults or adolescents use against intimate partners (includes in-laws) to control and have power over them."*

## Cultural Relevance

For purposes of clarity the definition used by this guide is:

> *" Cultural Relevance is the valuing of cultural differences by identifying the values, beliefs and cultural experiences of patients and using individualized relationship based interaction(s) that value, respect and are relevant to the patient served."*

# C. Why Address Domestic Violence During Pregnancy?

## Health Reasons

National studies on domestic violence indicate that there are several health problems associated with physical and psychological abuse such as: drug/alcohol use, chronic fatigue, headaches, anxiety, depression, irritable bowel syndrome, late entry into prenatal care, skipped appointments and eating disorders (McFarland, 1998). Studies indicate that women who experience physical abuse during pregnancy are at higher risk for miscarriages and low birth weight babies (Bullock, 1989).

## Best Practices

Identifying domestic violence during pregnancy can increase safety for the pregnant woman and her infant. In 1985 the United States Public Health Service Surgeon General, after reviewing various studies, recommended routine screening for perinatal domestic violence during prenatal care. Since then the American College of Obstetricians and Gynecologists, American College of Nurse Midwives, American Medical Association and American Nursing Association and the Family Violence Prevention Fund recommend routine screening for intimate partner violence during pregnancy. A number of states promote universal screening in all prenatal clinic settings in accordance with American College of Obstetricians and Gynecologists guidelines to screen pregnant women once per trimester and once during postpartum visits.

## National Statistics

National statistics indicate that nearly one third of US women will be physically abused by a current or former partner during their lifetime (Commonwealth Fund, 1999). A CDC study that reviewed the literature for research on the prevalence of domestic violence during pregnancy found that pregnant women reported experiencing domestic violence during pregnancy between .9% and 20% with the majority of studies ranging between 4% to 8 % (Gazmariaian, 1999). Gazmariaian noted that due to variability in the definitions of violence, methods for administering the screening questions, clinical settings and the questions asked accounted for the wide range of prevalence numbers. It is important to note that although only 7% of women will experience pre-eclampsia or gestational diabetes, routine screening for these conditions is standard practice in all prenatal care protocols. Yet with a similar to higher number experiencing domestic violence there is no routine screening for domestic violence.

## Washington State Statistics

During 1998 1 in 5 women age 18 or older surveyed on the Washington State Behavioral Risk Factor Surveillance System reported experiencing some physical injury from an intimate partner during their lifetimes. One in 13 women reported going to the doctor because of an injury from an intimate partner, and a similar number reported that they needed to see a doctor, but didn't.

In 2000, approximately 6% of childbearing women in Washington State reported experiencing physical violence by a husband or partner around the time of pregnancy (12 months prior to pregnancy through 3 months postpartum). This represents an estimated 5,184 women statewide. This estimate is based on women's responses to the 2000 Washington State Department of Health Pregnancy Risk Assessment and Monitoring System mail and telephone survey, which asks postpartum women about physical abuse prior to, during, and after pregnancy.

## Prenatal Care: An Opportunity To Identify Domestic Violence

Prenatal and postpartum care visits provide an ideal opportunity to identify the occurrence of domestic violence because prenatal providers:

- See women frequently and can build a trusting relationship;
- Usually see the woman alone which allows for privacy;
- Routinely ask questions about lifestyle as it relates to health and birth outcomes; and
- Are in a medical setting, which is perceived as a safe place to disclose sensitive information that will be held in confidence.

# D. Challenges to Implementation

## Lessons Learned in the PPADV – ICHS Project

Implementation of domestic violence activities in a community clinic setting will present challenges. The lessons learned from the PPADV – ICHS Domestic Violence Screening/Intervention Project reveal that the challenges come from within and outside the clinic setting. The following six issues will affect a clinic's ability to implement culturally relevant domestic violence identification activities. These issues are listed separately for the purposes of clarity. During implementation of any domestic violence identification system these issues are intertwined. Each significantly impacts the relationships required for a sustainable, culturally relevant system of care for pregnant and postpartum patients.

## Trust

Trust was an all-encompassing issue for the PPADV-ICHS Project. Trust was key to developing a relationship for patient disclosure due to cultural issues, immigration status and safety issues. Trust was critical to providers to feel comfortable with patients and referral sources.

Survivors and patients indicated that they needed to "trust" their provider before feeling comfortable to disclose domestic violence. The following statement from a survivor reflects this reluctance "I would not tell my doctor about my abuse from my husband because I don't want to discuss my private life with someone who is not close to me." Patients and survivors reported that the provider being "friendly" and using "chit chat" was a way of building a trusting relationship with them. A common theme of ICHS patients is reflected in the following statement, "The health care provider should make friendship with the woman to gain her trust."

The need for a trusting relationship makes referrals to outside agencies more complex as well. Frequently, the patient would disclose to the provider but would not want referrals either within or outside the agency for further assistance. Project staff found that it took more time than anticipated for patients to move to the next level of intervention, a referral, even if the resource was a culturally relevant domestic violence agency. Trust was key to this process.

Providers surveyed on screening practices indicated that they felt more comfortable asking about domestic violence when "the client trusts me." Identification is dependent on creating a trusting relationship in order to ask questions about violence. When asked to elaborate on this, an ICHS provider stated, "I will try to build a relationship with them to get them to trust me as a person first, then they can tell me. Sometimes they will never tell me; sometimes they will tell me because they know I am new and not from the community." The PPADV-ICHS Project had more referrals from non-perinatal patients than from perinatal patients. The OB Coordinator indicated that this was due to the fact that a relationship over time with the provider "built trust". Patients would disclose abuse to the provider long after delivery because they felt that trust.

Trust issues are an even greater challenge for the provider when they are the care provider for both the victim and the perpetrator. This is not uncommon in community clinics but it does present a dilemma on how to create trust and provide effectives service for the victim and services to the perpetrator.

Providers and referrals: Trust was a factor with providers in considering a referral out for services. Survey results indicated they did not know the resources in the community for domestic violence. In response to this, the project sent out a complete resource list identifying all agencies providing culturally relevant services for patients. In spite of efforts to better inform providers, referrals to the in-house Project Coordinator increased but referrals to outside agencies did not increase from providers. Informal discussions with providers revealed that they want to refer to resources they "know to be trustworthy" (in-house advocate or a resource they have worked with previously) rather than refer out to resources they do not know.

## Language

Language is key to a system of domestic violence identification and educational effort to increase understanding of domestic violence with non-English speaking patients. There are two aspects of language that are significant challenges: translation and interpretation.

Translation of concepts and information is highly complex and not easily addressed. The language used for domestic violence is diffuse and filled with nuance unique to mainstream culture. Terms such as "power and control", "abuse", "emotionally harmful", and "put-downs" may need little explanation for English speakers who live in mainstream culture. Non-English speaking patients or those with limited English skills from other countries will not understand standard screening questions, posters or culturally based explanations that do not relate to their life circumstances.

The PPADV-ICHS Project learned early on that direct translation of domestic violence materials may be confusing rather than helpful. In many languages the terms and/or nuances of domestic violence may not exist or will require complex explanations about mainstream culture and the response to domestic violence in this country. The PPADV-ICHS Project found that national translations of materials about domestic violence did not adequately address domestic violence issues for patients served by the clinic. There are not "standard" translations for languages that reflect the geographic and regional differences of the patients served. Translations must be personalized to the population served and their culture, dialect and preferences. This makes development of a "standardized" tool or materials a challenge.

Interpretation services have all of the concerns of translation with the additional complexity of interpersonal factors. Interpreters will have class, gender, education and attitudinal differences from those individuals who need interpretation services. During focus groups with ICHS interpreters, it became apparent that although providers ask direct questions, interpreters may adjust the questions to make them more "easy" or "less direct" or "softer." An ICHS provider acknowledged that interpreters might change questions, "Well, you know, I never know how it's being interpreted, which is another whole issue about asking those questions." Interpreters need background and/or training in domestic violence to assure that they can interpret the questions and information about domestic violence within a cultural context.

Interpreters must be carefully selected to assure total confidentiality. It is noted in domestic violence literature that perpetrators of abuse use children, family members or friends to keep tabs on or to control the victim. Therefore, using children, family members or individuals known to the patient for discussing domestic violence places the patient at increased risk for abuse. Providers and clinics must be very knowledgeable of the interpreters they use and must be clear about the process of domestic violence identification.

## Beliefs about Domestic Violence

The definition and nature of domestic violence is inclusive, complex and challenging for providers, community members and victims to grasp. The PPADV- ICHS project found some common beliefs we labeled as "myths" that are held by the different cultural groups served as well as the providers who serve them. The following reflects the comments of providers and patients during focus groups and interviews:

Myth: Domestic violence is only physical violence that results in an injury to an intimate partner.

Fact: This view discounts the impact of emotional abuse and power/control tactics on the victim's physical and mental health. Data from survivors of domestic violence indicate that physical violence from a partner is less debilitating than non-physical power and control tactics such as: isolating the victim from family and friends; demeaning comments in the presence of others; withholding money, shelter or food; physical threats toward the victim's children, parents or pets; forced sexual activities; and threats to the immigration status of the victim or family members.

This view also assumes that the "intimate partner" is the only perpetrator of violence. In some cultures, it may be members of the family, such as a mother-in-law, who perpetrate violence.

Myth: Domestic violence is a one time event or an isolated incident.

Fact: Domestic violence is a pattern of attacks over time to keep the victim controlled by the perpetrator, not a single behavior or interaction. Emphasis must be on the pattern of behavior that leads to control of the victim.

Myth: Power, control and demands for sexual relations are a part of a husband's or partner's rights within a relationship.

Fact: Understanding the rights of both partners in an intimate relationship require shifting attitudes and beliefs about intimate partner relationships. When sexual relations are forced upon a partner that partner's rights have been violated.

This myth permeates the clinic staff as well. During staff training, this myth in particular stimulated staff to re-evaluate their views about power and control behavior. Some community clinic staff are likely to be victims or perpetrators of violence in their own relationships. This can result in deep resistance to or overzealous implementation of domestic violence prevention activities. Agency administration must be prepared for disclosures by staff as victims or perpetrators.

Myth: Domestic violence is 'caused' by stress, drugs, alcohol or the behavior of the victim.

Fact: Domestic violence is a learned behavior and not caused. Frequently alcohol or drugs co-occur with violence but they are not the cause of the violence. Studies on perpetrators indicate that even if the perpetrator gives up alcohol, or stress is reduced, the controlling behavior will continue (Schronstein, 1997). Community providers stressed that the community served by ICHS must "let go of stereotypes of psychological abuse mislabeled as mental illness."

## Confidentiality

Confidentiality is linked to the trust that a patient has in the system to protect information.

No matter how many safeguards (training in confidentiality, special case files for DV, locked files) are in a system it can be difficult for providers to totally assure that patient disclosures are confidential in settings that are small or when services require an interpreter. Each clinic will face challenges with clinical records, use of interpreters, and use of referral sources.

Community members emphasized, "Be sure confidentiality is stressed…. This is a huge problem." A client observed, "I talk to the primary doctor with trust, but everyone can take a look in the chart without staff [present]" or "I think it is not good to write DV in the patient's file. I am afraid too many people will know about my situation if the file is not kept in a locked cabinet."

The nature of community clinics is to be a part of the community. This brings complications for assuring confidentiality for victims. For example, community clinics hire staff from the community to work in sensitive areas such as direct medical care, medical records and interpretation. Frequently, staff members are the relatives, close friends or acquaintances of the victim or perpetrator making it more difficult for patients to disclose or the provider to ask about domestic violence.

## Safety

Patient safety is closely related to the confidentiality of the agency files. Disclosure of abuse can jeopardize the patient's safety and her status in the community. This quote from an interview with a survivor reflects the fear of not being safe. "I would not tell anyone until I left my husband because I am afraid other people will give my address to him and then my children will not be safe anymore." This presents significant issues for protocols that require documentation. Patients may not disclose because they do not want information in the chart even if confidentiality is assured. Providers cannot always assure confidentiality in a system that is staffed with community members. Since the victim's safety is at stake documentation may not occur as it should in charts. Patients frequently discussed that fear of retribution from the perpetrator was a reason why they did not disclose information.

## Cultural Challenges

There are several aspects of culture that make domestic violence identification complex.

Cultural layers surround the patient and provider. Each clinic has a variety of internal and external sub-groups that can hold conflicting beliefs and values regarding domestic violence. The PPADV ICHS Project identified four different sub-groups within and outside the clinic that impacted the implementation of the domestic violence identification services:

- Culture of the clinical staff
- Culture of the clinic administration
- Culture of the population served
- Culture of the community based services available to victims

It is critical that when developing an identification system that each of these groups is surveyed to locate the sub-groups beliefs and how this will impact the identification system.

Cultural groups are not homogeneous. Within each cultural group there are more layers of diversity that influences perspectives on culturally relevant service provision. These layers are related to gender, age, class, education, language spoken, war history with other cultures, acculturation and county of origin. The art of blending these various cultural layers is highly complex, unique to the setting and a challenge when dealing with an issue as sensitive as

domestic violence. How these layers of culture are negotiated is critical to building trust and relationship between and within each layer of the target group.

Cultural Taboos: Domestic violence is a private, personal issue not easily shared with those outside the family unit. In many cultures, domestic violence is viewed as shameful and embarrassing. The API cultures served by the ICHS clinic viewed the disclosure of domestic violence as a deep violation of the family. Typical patient comments about disclosing violence in the family include: "Asians don't like to talk [about family issues]. They like to keep it within their families" and "We were taught to keep dirty things within the wall of our house because we do not want to lose face." These beliefs go far beyond the mainstream feelings of shame. This required providers to be very sensitive to the significant difficulty, isolation and fear created for a victim who might disclose abuse.

In conclusion, domestic violence identification presents challenges that require time to develop trusting relationships, the ability to adapt clinic procedures, methods to assure safety and confidentiality, accurate translation and confidential, skilled interpretation services for patients being served. Clinics may be limited in the degree to which changes can be made but even small changes within the clinic can result in major changes for the women and their infants who experience domestic violence.

## E. Small Steps Save Lives

The challenges can feel overwhelming. But the consequences of doing nothing result in deaths. Washington State is one of several states that conduct fatality reviews. Since 1997, at least 209 people died at the hands of domestic violence perpetrators in Washington State. Of women murdered in Washington State, over one third are killed by their current or former intimate partner. (Washington State Domestic Violence Fatality Review, 2002). **Doing nothing is not an option**.

It has been the experience of the PPADV –ICHS Project that the process to overcome the challenges requires a gradual, sustained effort that is made up of small steps integrated into existing clinic activities. The goal for instituting domestic violence identification activities is to offer support, comfort and resources to a patient who experiences domestic violence. This goal can be achieved by targeted small steps once the clinic has a completed assessment of their current status.

As opportunities arise clinic administration and interested staff can integrate domestic violence activities when updating existing systems. The following small steps are examples of how domestic violence identification activities can be folded into existing activities and require a minimum of agency resources:

- Health education and outreach workers can place culturally relevant translations about domestic violence, with safety cards, in restrooms for patients to self-refer to culturally relevant agencies (see Appendix D for examples).
- Place culturally relevant brochures in waiting areas with other health related brochures to promote patient education.

- During in-service trainings for front office staff and interpreters provide information on "cues" of domestic violence and methods for handling these observations by a local domestic violence advocate trainer.
- Provide opportunities during staff in-service trainings for information about domestic violence by local domestic violence advocate trainers as it relates to staff contact with patients using the PPADV Curriculum materials (see Appendix B).
- Develop policies that will be used to handle intimate partner violence of employees and workplace violence while updating existing agency personnel, Employee Assistance Program (EAP) and safety policies.
- Provide domestic violence training for staff supervisors/managers on agency safety policies, how to address staff domestic violence issues, use of EAP, and ways to support staff on cases of domestic violence.
- Provide opportunities for staff to meet domestic violence agency staff by inviting them to a staff meeting or retreat.

These small steps can be integrated into the agency over a period of a year and can make a significant difference to patients and their babies.

## F. Next Steps

Every community clinic is confronted with the lack of time, staff, and funding to do all they might like to do. Implementing a basic system for domestic violence identification, that will be sustained, must be a gradual effort made up of the small steps listed previously. It will require the following from agency administration:

- Planning
- Commitment
- Patience
- The assistance of this Guide

This guide is NOT a cookie cutter method of developing materials for a community clinic but rather a set of processes to assess and plan targeted activities to increase safety and culturally relevant interventions for the pregnant/postpartum patients in the community over time. It is tempting to simply turn to the back pages of this guide and find items useful to the clinic setting. *Resist this temptation* as the next step. Based on the experience of PPADV - ICHS Project, completing an assessment of the community clinic staff, administration, community served, and domestic violence service providers will lead to the best possible outcomes for patients and the clinic.

It is suggested that a member of the staff who has good knowledge of the clinic and community and has an interest in the issue of domestic violence be given authority to work on this issue. This person can review the manual indepth. The assessment tool is a written equivalent of the process that most community clinic managers do in their head daily when planning a health education effort or new program activities. The difference here is that it is written down and recorded. Do not be put off by the basic nature of this tool. It will lead

to a simple targeted plan that will survive through the ever-changing environment of community clinic existence.

A community clinic is a dynamic entity. The materials that follow are designed to be sensitive to this ever-changing environment. The assessment tool can be used to monitor the progress of implementing a domestic violence identification system as part of a quality assurance system within the clinic setting.

# III. Assessment and Targeted Plan

## A. Model For Assessing The Clinic System

The starting point for developing any culturally relevant process is to have first hand accurate knowledge of clinic staff, clinic administration, patients served and community-based domestic violence referral agencies. In general, most community clinics have elements of a domestic violence protocol and screening tool. This assessment process provides a simple structured method to identify strengths and barriers in the existing system. This will lead to a small stepped, targeted plan.

The PPADV – ICHS Project selected elements from the PRECEDE/PROCEED Framework, (Green and Kreuter, 1980) a health education model of behavioral change, to develop this assessment tool. The Educational Diagnosis Phase within the PROCEED Framework contains three key factors that must be identified to locate strengths and barriers to change behaviors toward an identified health behavior. The three factors are: Predisposing Factors, Enabling Factors and Reinforcing Factors.

Predisposing Factors are defined as "any characteristic of a patient, consumer or community that motivates behavior in relation to health" such as knowledge, attitudes, beliefs and values.

Enabling Factors are defined as "any characteristic of the environment that facilitates health behavior or any skill or resource required to attain a behavior. (Absence of the characteristic or skill will block the health behavior.)" These characteristics could be money, provider skill or provider demographics, skill level of community service providers, or the characteristics of the population served.

Reinforcing Factors are defined as "rewards or punishment following or anticipated as a consequence of the health behavior." Examples of reinforcing factors might be that a patient finds the service useful or that the providers notice improvement in the patient's well-being or that providers gain positive recognition on the care they provide.

## B. The Assessment Process

The assessment is designed to be an individualized quality assurance tool. The initial assessment is a baseline of the strengths and barriers for domestic violence identification within the clinic and community. The baseline assessment results can be interpreted to develop a simple small step plan that targets one or two items that are feasible and effective to increasing a culturally relevant domestic violence identification system within a specific time period (i.e. 6 months or 1 year). At the end of the defined time period the assessment is repeated to evaluate the strengths and barriers against the baseline to see if there has been progress. Based on the comparison, adjustments can be made to the targeted plan based on the assessment results. This process allows a community health clinic to establish its own goals, benchmarks and activities that are paced to the needs of the staff, administration, the population served, and local domestic violence service providers. The following example will demonstrate how to use the assessment and targeted plan for implementing activities for

domestic violence identification. The assessment process will be described in detail at the conclusion of the example.

# C. Agency ABC: An Example

## Background

The Perinatal Coordinator has been at the ABC Community Clinic for over five years. Since her sister's experience with domestic violence last year, she has become more aware that domestic violence might be the cause of patients missing appointments, somatic complaints and non-compliance with medical advice.

The Coordinator is allowed 2 hours a week for one year to work on domestic violence identification issues in the clinic. She decides that she will use the assessment tool and targeted planning process outlined in this manual.

## Clinic and Community Characteristics

- Approximately150 births per year.
- Patients are predominately non-English speaking and recent immigrants.
- Medical providers are predominantly white, middle class.
- Interpreters also work as medical assistants.
- There is a new clinic-wide initiative to reduce smoking for all patients that is well funded.
- The Community is composed of three different cultural groups.
- There are two very different Domestic Violence Advocacy agencies serving the community but with limited language capacity.

## Using the PPADV Assessment Tool

The Coordinator reviews the PPADV Assessment Tool using the Assessment Question Guide in Appendix A. She determines that she can answer most of the questions based on her experience with the clinic staff, administration and the domestic service providers in the area. She does not have enough resources to gather data with focus groups, complete interviews or surveys. If she has insufficient information she will rate the question as a NO and then develop a plan for getting this information during the year. She completes the PPADV Assessment Tool in less than 2 hours.

## Completed PPADV Assessment Tool

Agency Name: **ABC Agency** Assessor: **Coordinator** Date: **4/2/04**

(1) Score each question in each box with a 1 for YES and a 0 For No. (2) Please note that N/A means not applicable – Do Not Score. (3) See question guide to assist in clarification.

| Questions/Targets | INTERNAL | | EXTERNAL | | Totals |
|---|---|---|---|---|---|
| | Staff | Administration | Community | Domestic Violence Service Providers | |
| ***Predisposing*** | | | | | |
| 1. Is there a basic level of knowledge about domestic violence and domestic violence resources? | 1 | 0 | 0 | 1 | **2** |
| 2. Are attitudes supportive to domestic violence activities? | 0 | 1 | 0 | 1 | **2** |
| **Totals:** | **1** | **1** | **0** | **2** | **4** |
| ***Enabling*** | | | | | |
| 3. Is sufficient funding available? | 0 | 0 | 0 | 0 | **0** |
| 4. Are formal and informal power structures supportive of domestic violence activities? | 0 | 1 | 0 | 1 | **2** |
| 5. Can the decision-making processes be influenced in support of domestic violence activities? | 1 | 1 | 0 | 0 | **2** |
| 6. Are staff skilled and culturally competent, regarding domestic violence, for the population served? | 0 | 0 | N/A | 0 | **0** |
| 7. Are agency policies (protocols) sufficient to provide effective, culturally relevant service? | 0 | 0 | N/A | 0 | **0** |
| 8. Is there sufficient capacity (staff/time) and resources (trainers, consultants, services, advocates) to provide effective, culturally relevant services? | 0 | 0 | N/A | 1 | **1** |
| 9. Are there effective relationships in place to promote and provide effective, culturally relevant services? | 1 | 1 | 0 | 0 | **2** |
| **Totals:** | **2** | **3** | **0** | **2** | **7** |
| ***Reinforcing*** | | | | | |
| 10. Do patients experiencing domestic violence report feeling supported, respected for their choices and that services were culturally relevant to their situation? | 0 | 0 | 0 | 0 | **0** |
| 11. Are there meaningful incentives/recognition for providing culturally relevant care for victims of domestic violence? | 0 | 0 | 0 | 0 | **0** |
| **Totals:** | **0** | **0** | **0** | **0** | **0** |
| **Grand Total:** | **3** | **4** | **0** | **4** | **11** |

## Assessment Results

The PC reviews the Assessment tool using the guidance in Appendix A. The results are:

### Overall Results

1. There are strengths within the clinic administration (support, decision making can be influenced, attitudes are positive toward DV, allowing resources for PC time) which can be utilized.

2. The DV Services providers are knowledgeable about domestic violence and the cultural groups served by the clinic.

3. The clinic has limited knowledge of how the community views domestic violence.

### Predisposing Factors

The predisposing factors have a mix of barriers and strengths.

Strength: The clinic staff have basic knowledge about domestic violence and knowledge of resources.

Barrier: Attitudes within the staff, administration and community are not supportive to addressing domestic violence.

### Enabling Factors

The enabling factors have a mix of barriers and strengths.

Barrier: There is no additional funding in any category but administration will support the coordinators time for one year.

Strength: The informal group support for DV activities is coming from clinic administration and the DV Advocate agencies.

Strength: Decision making processes in administration and clinic staff can be influenced by the Coordinator.

Barrier: Cultural competence regarding DV is lacking in clinic staff, administration and in the DV advocacy agencies.

Barrier: There are no protocols or policies in effect in any of the target groups.

Strength: The DV advocate agency has the capacity to provide some services.

Strength: The relationships between the staff and administration are strong and positive.

Barrier: Relationships with the community on this issue are limited.

Barrier: Relationships with the DV agencies are non-existent.

### Reinforcing Factors

Barrier: There is no system in any area that gains reports on how patients are experiencing DV services from the clinic.

Barrier: There are no incentives or recognition for providing care to victims of domestic violence at any level.

## Developing the Plan

Based on this assessment the Coordinator could select a number of activities to address these issues. In selecting the most appropriate next steps for this agency, the following realities must be considered:

1. Planning and organizational time are limited to 2 hours of Coordinator time per week.

2. The staff is overwhelmed by the new smoking initiative and do not have much time left over for a new "project".

3. The activities taken on for domestic violence this year need to show some measurable progress to administration.

Based on the assessment and the realities listed above, the Coordinator decides to focus on three goals this year:

1. **Predisposing**: Increase staff attitudes about promoting domestic violence prevention activities in the clinic for all patients and for pregnant women (Question #2).

2. **Predisposing**: Increase knowledge about community attitudes toward domestic violence and pregnancy (Question #2).

3. **Enabling**: Increase trust and working relationships with domestic violence service providers in the community (Question #9).

The Coordinator reviews suggested activities (Appendix B) related to each of the questions (#2 and #9) and finds four activities that will address the three goals. The following activities were selected:

1. Use of the Myth and Fact Game with staff and administration during October as a part of the usual Domestic Violence Awareness Month activities. In place of the annual one-hour training usually allotted for DV training, the game will be used to bring up common myths and facts about domestic violence within the community.

2. Work with DV service provider staff regarding the Myth/Fact Game and the agency policies on how to deal with DV with staff as a method to increase relationships with the DV service providers.

3. Begin the process of gaining more information on how the various cultural groups served by the agency view domestic violence by talking with interpreters who work with the agency, community leaders, staff who represent the community and the DV service provider.

4. Re-evaluate the plan with the executive director in six months, using the Assessment Tool to see if progress has been made.

The coordinator placed these activities into the planning documents for training, agency quality assurance plan and the coordinator's work plan.

This concludes the example.

# D. Administration of the Assessment

## The PPADV Assessment Tool

The blank PPADV Assessment Tool is in Appendix A. There are eleven assessment questions organized in relation to the three factors listed above. The content for each question is based on the experience of the PPADV - ICHS Domestic Violence Project. The first two questions relate to ***Predisposing Factors.*** The Predisposing questions relate to knowledge about Domestic Violence (Question 1) and Attitudes about Domestic Violence (Question 2). Questions 3 through 9 are related to ***Enabling Factors***. The Enabling questions relate to the presence (a strength) or absence (barrier) of seven items that can facilitate activities related to domestic violence identification. Questions 10 and 11 are related to ***Reinforcing Factors*** that support the continuation of domestic violence activities such as consumer satisfaction and provider incentives.

## Who Administers The Assessment

The qualifications for who administers the tool are critical to obtaining the best possible information about the target groups in the most efficient manner. The best qualifications for the person(s) are:

1. Employed by the agency for at least 2 years.

2. Has authority from administration and the board to facilitate or direct change.
    a. Perinatal Coordinator
    b. Lead Behavioral Specialist
    c. Lead Nurse
    d. Lead Perinatal Doctor
3. Has a good working relationship with, and knowledge of, agency staff, the community and community-based service providers.

4. Bilingual bicultural member of the community group served in the clinic.

5. Ability to collect information without judging the cultural perspectives of target group respondents.

6. Has authority to convene workgroups, initiate interviews and/or written surveys of clinic staff, patients, survivors and community agents to respond to assessment questions.

## Who Is Being Assessed: Targeted Groups

There are four basic target groups for the assessment: Agency Staff, Agency Administration, Community Served and Domestic Violence Service Providers. Each of these target groups needs more definition.

Agency staff: Medical providers such as nurses, doctors, nurse practitioners, physician assistants, interpreters (contracted or on staff), receptionists, medical assistants, outreach workers, social workers, nutritionists, eligibility workers, dentists, psychologists, acupuncturists, paraprofessionals, and others who work directly with patients.

Agency Administration: Clinic managers, directors (executive and medical), board members, fiscal officers, attorneys, secretarial staff, billing clerks, and office assistants.

Community Served: This would include, but is not limited to: all clinic patients, prenatal patients, domestic violence survivors, community leaders, families, and religious leaders that represent all cultural groups served by the clinic. For the sake of clarity, the assessor may choose to select the population most frequently served, how extensive or inclusive the definition of community might be for assessment purposes.

Domestic Violence Service Providers: Existing agencies and individuals who provide services to domestic violence victims such as: Domestic violence advocates, shelter programs, housing, legal advocates, immigration services and legal systems.

## Scoring

This assessment will relate to your clinic only. It must be based on the information available to the assessor. The tool is in an Excel spreadsheet format which, if used as it was designed, will automatically provide assessment scores. Each question is designed for a Yes or No response. The assessor, based on the information available, must make a judgment to score each cell with either a (1) Yes or (0) No. There are four cells per question that relate to each target group (see Who is Being Assessed: Target Groups).

If sufficient information is **not** available to score the item as a YES or a NO then review the Assessment Question Guidance section of this chapter to stimulate your thinking about this question. If this does not help, either: 1) Consider a more full-scale assessment by using written surveys, focus groups or key informant interviews. Materials from the PPADV - ICHS Domestic Violence Project are available from Department of Health via email at judith.leconte@ doh.wa.gov or phone 253-395-6739; or 2) score it as a NO response and develop an activity in the targeted plan to gain more information so an informed response can be developed.

Each cell must have a numerical score (either a 1 for YES or 0 for NO), with the exception of the three cells under Questions 6, 7, and 8 under the target group "Community Served". There will be a total score for the entire set of questions. Sub-totals will occur for each question across the four target groups and for each section (Predisposing, Enabling, Reinforcing) for each target group. If this is the first administration of the tool it is a baseline assessment with no basis for comparison. If so then simply review the assessment looking for barriers (0) and strengths (1). If this is a repeat evaluation the scores can be compared between the baseline and the current numerical scores to evaluate progress.

## Interpretation of Results and Key Patterns

In general, the higher the numerical scores the more there are sufficient strengths in the system for developing a domestic violence identification system. The lower numerical score will reflect there are barriers present that will require preparatory work for a successful outcome. Cells with the response of "NO" (0) are identified as barriers. Cells with the response of YES (1) indicate strengths. This does not mean that they will be perfect or that the assessor cannot look to make refinements.

### Key Patterns

Question Clusters: The four key questions in this assessment tool that will impact successful implementation of domestic violence identification activities are:

No. 2: Are attitudes supportive to domestic violence activities?

No. 4: Are formal and informal power structures supportive of domestic violence activities?

No. 5: Can the decision-making processes be influenced to support Domestic Violence activities?

No. 8: Is there sufficient capacity (staff time) and resources (trainers, consultants, services) to provide effective, culturally relevant services?

If there are zeros in all four cells for all four questions, the agency and community is at the most basic level. **DO NOT CONSIDER IMPLEMENTING PROTOCOLS OR TOOLS** if you are at this stage. It is best to focus energy on gaining more information and building relationships within each of the target areas around each of these key questions. Develop a targeted plan toward one or more of these key questions or focus on one target group for the designated time period. Use the Suggested Activities Section in this appendix to assist with some activities that might lead to building strengths or reducing barriers.

Individual Questions: If you have zeros in all four cells for any one of these questions this indicates a significant challenge. The first step is to provide support to the strengths that are in place. Then identify the key elements of those targets that provide barriers. What are the barriers? How do they impact domestic violence identification? Work with members of the target group to develop a list of strategies that will reduce the barrier and build strengths.

Individual Questions 1, 3, 6, 7, 9,10, 11: Zeros on Questions are important to planning a targeted plan but are not tied to any pattern.

Question # 1 is about the knowledge level. This can be easy to target in a plan. See Appendix C for informational materials for perinatal providers.

Question #3 is focused on funding issues.

Question #6 is focused on staff competence. Look to Appendix B for assistance in developing a targeted plan.

Question #7 relates to protocols and tools that may be limited or ineffective or in need of revision. Appendix E contains ICHS samples also available on websites to provide information on protocols and sample tools and how to implement. The use of the chapters will vary depending upon the information collected and the activities that best fit the clinic need.

Question #9 relates to the effectiveness of relationships within the clinic, between patients and staff, and between the clinic and the community.

Questions #10 and #11 are related more to how the agency deals with incentives and consumer feedback. The suggested activities found in Appendix B are available to provide discrete activities for each question and target group.

## Targeted Plan

### Developing a Plan

The targeted plan can be written in any format or integrated into existing Community Health Clinic planning forms. The key point is to write out a clear action plan for addressing the issues discovered from the assessment. The Targeted Plan for Domestic Violence Identification Activities Form (see Appendix B) is set up for each of the questions from the assessment by the target group assessed. It is designed for immediate and long-term use.

### How to Use Suggested Activities in Appendix B

The activities selected for the targeted plan must flow from the information collected on the barriers and strengths for the specific clinic. Each clinic is unique. An activity that will work in one setting or environment will not match for another clinic setting. The assessment information collected is the culturally relevant foundation for developing activities that will match the cultural identity of the clinic, population and community. These culturally relevant, meaningful activities will increase or refine the domestic violence identification of pregnant/postpartum women in your clinic.

## Five Steps to Completing a Targeted Plan

Step1: Review assessment interpretation for strengths and barriers.

Step 2 Based on the strengths and barriers select one to two areas to develop a plan.

Step 3: Develop a plan based on the knowledge about the program, resources and time constraints. Be specific, targeted, time limited and clear in the plan (for sample plans for each question area see Appendix B).

Step 4: Implement the plan.

Step 5: Reassess within the time period selected.

# IV. Training

## A. Introduction

Training is considered critical to assure skilled, culturally competent staff who will provide effective services. The key is flexible, effective training methods. There are so many competing training topics for community health staff that training methods must be innovative, easily integrated into normal clinic functions, and responsive to the needs of those trained. The barriers to training are many. First, Community Health Clinic staff are required to attend training on a wide variety of topics. Domestic violence training is often considered by staff as " optional," or "not really a health issue" or "not required" so it can be easily dismissed. Second, domestic violence training may be uncomfortable. It involves issues that may be experienced by staff in their personal lives or bring up opinions or views that may result in differences and conflict. Third, domestic violence training materials tend to focus on mainstream values and beliefs. Therefore, suggestions and ideas presented may not be relevant for the cultural group served by the clinic. Complaints that the Domestic Violence training is repetitive are correct because the information is not presented in the cultural context for the patients that are served. Fourth, time is at a premium for clinic staff so training must be brief and relevant to clinical practice.

The PPADV - ICHS Project tried to adapt traditional mainstream training items in the Washington State Perinatal Partnership Against Domestic Violence curriculum so that they would be relevant to the Asian Pacific Islander populations served by ICHS. Informal feedback from community clinic providers (Doctors, ARNPs, Family Health Workers, Interpreters, front desk staff) regarding the initial didactic training was that it was not new information nor did it relate exactly to their work with API patients. They wanted more immediate, less time consuming methods of training about domestic violence. Providers requested training materials that are:

- Focused on the cultural needs of the patients they serve.
- Quick and easy to read with basic facts and websites attached for more information.
- Staged to when the provider can apply it.
- Not so prescriptive. Provide a range of alternatives that will match the cultural group being seen and the individual style of the staff person.
- Interactive such as providing case studies about cultural differences and challenges.

The training package for PPADV - ICHS addressed these issues by developing individualized small training for front office/reception staff, interpreters, outreach workers and provider staff that was short, focused on the way they might become involved with victims or perpetrators. The trainings were developed with the same domestic violence advocates who would be serving the patients so that a relationship was built between the clinic and the advocate community.

## B. Provider Fact Sheets

The PPADV - ICHS Project piloted eight Provider Fact Sheets on various topics that were of concern to ICHS providers and staff. ICHS staff wanted a "quick overview" of specific topics in domestic violence that they could refer to as needed. The topics were based on requests from medical providers who wanted clear, easy to read "refreshers" they could use immediately.

The PPADV –ICHS project used the fact sheets as follows:

- As the basis for brief in-service trainings.
- As part of a consultation with a specific provider.
- As a method for providing specific information to part-time or new staff who were unable to get to training.
- As a refresher for staff on topics previously covered in training.
- As part of a packet of materials.

The provider fact sheets can be sent in electronic format or hard copy. This offers methods to assure a wider distribution and ease to get information quickly. The feedback from various providers was that these were helpful and met their needs.

The provider fact sheets were specifically designed for the ICHS clinic and match the protocol. Adjustments would need to be made to fit the clinic setting. It is recommended that if a clinic chooses to use these materials that they be reviewed by the director and staff of a local domestic violence advocacy agency to assure accuracy and safety factors.

The fact sheets listed below can be found in Appendix C:

- 60 Second Domestic Violence Intervention in a Health Care Setting/24-hour Resources
- Provider Guide to Domestic Violence Screening Questions
- Provider Guide: What Is Sexual Assault?
- Mandated Reporting Requirements for Child and Vulnerable Adult Abuse
- Provider Guide: Documenting Suspected/Disclosed Domestic Violence
- Cultural Values: Through Language and Actions
- A Policy Statement on Domestic Violence Couples Counseling
- Domestic Violence and the Workplace: Information and Resources
- Washington State Domestic Violence and Pregnancy Facts

The materials in this section rely heavily on the Washington State Perinatal Partnership Against Domestic Violence curriculum (see Resources on how to obtain this comprehensive curriculum), and the work of the Asian Pacific Islander Coalition Against Domestic Violence (APIADV). (See acknowledgements for agency members.)

The Fact Sheets have been used in electronic format or placed at clinic workstations or provided during training sessions. They can also be used as a quick and informal in-service training "sound bite" for discussion purposes.

## C. Curriculums For Health Care Settings

There are training documents that can be used or adapted to fit the needs of a community health clinic setting by Domestic Violence Advocate Trainers. A brief summary of these materials and how they can be obtained follows:

### Perinatal Partnership Against Domestic Violence Curriculum, Revised Edition 2001.

This curriculum was developed by Patricia Bland, M.A.. It includes training modules that can be adapted to time frames, cultural competency materials, case scenarios all involving pregnant/post partum patients that can be used to stimulate case conference discussions about domestic violence and how providers can screen and refer within a limited time frame.

Order Information: Contact Leigh Hofheimer at 206-389-2515 or email at leigh@wscadv.org.

### Improving Health Care Response to Domestic Violence: A Trainers Manual for Health Care Providers 1998

This manual was authored by Anne L. Ganley, PhD. It includes an overview of how to use the manual, sections on domestic violence and cultural competency, Screening and Assessment, Domestic Violence and Practical Applications, Legal Issues, Resources and sample materials.

Order Information: Contact The Family Violence Prevention Fund at (415)252-8900 or website: http://www.fvpf.org

# V. Client and Community Education

## A. Introduction

The PPADV - ICHS Domestic Violence Project discovered that the education of the clinic staff is only one aspect of developing an identification system. Patients, their family members, friends, religious leaders and neighbors all need to be aware of domestic violence in the community and to know that community clinic staff can be of help. To this end the PPADV - ICHS Domestic Violence Project developed materials for patient and community education. These materials reflect the educational needs of the community and patients served by ICHS. They may not reflect the education needs of other clinics. They are being shared as examples of community and patient education. Adaptations can be made but must be carefully reviewed by members of the community who are well aware of the culture of the community served and what would fit best for them.

In the experience of the PPADV - ICHS Project it is important to carefully craft adaptations of domestic violence materials because this is a sensitive issue. It is wise to use the interpreter staff, domestic violence advocates and interested patients to review the English examples and to discuss how these might be translated or interpreted considering the diversity within each cultural group served by the clinic. It was the experience of the PPADV - ICHS Project that nationally developed materials did not always reflect the regional and geographic differences of specific cultures. The adaptations developed by the PPADV - ICHS Project for materials reflect only the populations served by the clinic. The Project has translations of some materials in Chinese, Tagalong, Vietnamese, and Korean available upon request (contact Judith Leconte, 253-395-6739).

## B. ICHS Brochure: Why Are We Asking You About Safety?

This brochure (see Appendix D) has been used at ICHS to allow prenatal patients to be aware of screening services in the prenatal clinic. The brochure is part of the prenatal packet of materials and explained at the time of the first visit with the clinical nurse. It can be adapted to other clinics but should be reviewed by local domestic violence staff, interpreters, clinic staff and patients to assure that it is appropriate. The language in the brochure can be changed to reflect the clinical practices of the clinic.

## C. Domestic Violence Flyers With an Order Form for the Safety Cards

This restroom flyer (see Appendix D) is an example of information that can be place in the stalls of clinic restrooms with a holder for the Department of Social and Health Services safety cards. This allows for privacy and for the patient to choose a method of action on her own. The patient may not want to disclose to the clinic but might call the 1-800 number or use the information on the card to create a safer environment. The card comes in several languages at no cost to Washington State clinics.

These materials can be adapted by other states and/or other community settings such as churches, social service agencies, schools, WIC offices, Family Planning offices or social service offices that serve the community.

# D. Interactive Awareness Raising Activities

## Community Fairs

One of the most successful community activities for the PPADV – ICHS Project was the Health and Domestic Violence Community Health Fairs. Initially, the fair was designed to acquaint the clinic providers and staff with local domestic violence providers serving the various cultural groups. The community work group determined that just having the providers move from booth to booth would not assure contact with each community service provider. There was a goal to make the event fun and interactive. Twelve questions representing the myths about domestic violence were fashioned into a Bingo Game format. Each fair participant got a game card and had to verify their answers by going to specific booths. Usually a discussion occurred regarding the issue. Fair participants (medical providers, staff and some patients) and the domestic violence providers found the activity to be fun and to truly establish relationships between clinic staff and domestic violence service providers. A small prize such as candy or domestic violence pens, cups and materials can be given out after the game is completed. If you want more assistance with how to set up a fair please contact: Judith Leconte at 253-395-6739.

The Fact or Myth Game is in Appendix D for review and use. It may need to be adapted to fit your community. It is best to review it with local domestic violence advocates to assure accuracy and safety. It is suggested that this game could be tried with community groups and domestic violence service providers. There are a variety of creative ways this could be established.

## Domestic Violence Awareness: In Her Shoes

This activity was developed by abuse survivors to provide community groups, administrators and others an insight into the challenges faced by abuse survivors. The participants are assigned a script and must follow the script through the various stages of working through the system. After the exercise there is time for discussion. For more information on this item contact your local domestic violence advocate agency or Leigh Hofheimer of the Washington State Coalition Against Domestic Violence at 206-389-2515, Ext. 104.

# VI. Protocols and Tools

## Recommendations Based on the ICHS Experience

Adapting mainstream protocols and tools to fit a specific clinical setting exposes the complex and intertwined nature of the six challenges of implementation (Trust, Language, Confidentiality, Safety, Beliefs about DV, and Culture) mentioned previously. There are many excellent research studies that provide specific information on valid screening questions and protocol development. The PPADV – ICHS Project attempted to modify the Washington State PPADV protocols and tools using recommendations from the literature for mainstream and culturally relevant practice. The lessons learned were that adapting materials from the literature or "standardized" products is labor intensive and leads away from the cultural realities (i.e., resources that have the appropriate language but may not be perceived by patients as safe) of the population served. These 'realities' impact provider practices, patient comfort, and the way a protocol can be activated.

## Protocols

The protocol materials in Appendix E are the end result of a two-year process for the PPADV –ICHS Project. All providers agreed upon the protocol. Yet they did not follow the protocol consistently. In reality, the challenges of trust, confidentiality, safety, language, cultural taboos and cultural layers combined to have a deep impact on the process of screening. The following illuminate the reasons why the protocol was not followed:

- Providers must "feel" that their patient 'trusts" them before they will screen. If the relationship is not "right" then the question is not asked. A protocol should allow for this and remain flexible. (Trust)
- Providers may not be able to gain time alone with patients so screening may not be safe during clinic visits if the partner cannot be separated from the patient. (Safety/Confidentiality)
- Providers may not document in the chart if they have concerns about medical records not being confidential even when every method available has been developed to provide confidential records. (Confidentiality/Culture)
- Several providers and interpreters could not use direct questions for screening because the language equivalent was considered disrespectful in some languages or for patients who were younger or older. They wanted to vary the questions to convey respect. (Language/Culture/Trust)

Therefore, the protocol and tools in Appendix E are a "work in progress" for ICHS. It is not the end point. It can provide a guide but not the "ultimate" protocol. A protocol must deal with these issues and provide contingencies. The PPADV – ICHS Project did find that summarizing the 14-page protocol into a single flow chart did make the protocol easier to comprehend for some staff.

## Screening Tools

There were two sets of screening tools used for the PPADV –ICHS Project (See Appendix E).

1. DEDICATED TOOL. Initially, there was a dedicated tool that was placed in the confidential section of the chart that was approved by staff. The tool was not used because it was so inaccessible. It may work well for other clinics.

2. INTEGRATED TOOLS. Based on feedback from staff the screening questions were integrated into existing prenatal tools. This made the tools less confidential but more readily available to trigger providers to ask but in effect may have reduced documentation by some providers.

The PPADV – ICHS Project saw an increase in screening and referrals but documentation on the tools remained low. Had the project continued it appeared that there may have been a steady gain in documentation on the integrated tools.

There is no perfect solution for these issues but rather a constant modification of the screening tools and allowing for some variability on the use of screening questions (being direct or indirect or using the screening tool as a trigger for questions but having the provider document in a different place).

## Steps to Developing a Protocol and Tools

1. Know the attitudes of the internal culture (staff, administration) within the agency. Developing positive attitudes toward domestic violence identification activities and resources requires collecting information on provider knowledge and beliefs about the cultural groups served and the issue of domestic violence. There may be high variability between staff based on gender, age, country of origin, assimilation, class, and education. All of this must be taken into account prior to initiating development of materials.

2. Assure that the protocol addresses screening providers to building trust with patients, methods for dealing with confidentiality (how to get the patient alone or find a safe interpreter) and patient safety (how to provide a mini safety plan). This will involve identifying staff that can build trust with patients in specific cultural groups, interpreter services are confidential and match the geographic areas for the population served, relationships with culturally relevant resources. The difficulty in this step is finding the match between clinic staff, the cultural groups served and the culturally relevant resources in the community.

3. Involve staff and administration in the review of protocols and tools, the timeframes for getting the system in place and the methods for evaluating success.

4. Pilot the materials, debrief staff and modify the tools

5. Implement the materials.

6. Evaluate and revise as needed.

# VII. References


1. Schronstein, S.L. Domestic Violence and Health Care: What Every Health Professional Needs to Know. Thousand Oaks, CA Sage Publications 1997.

2. McFarlane J. & Gondolf, E. "Preventing Abuse During Pregnancy: A Clinical Protocol," MCN Vol. 23, Jan/Feb., 1998.

3. McFarlane J, and Bullock, L. "Characteristics of Battered Women in a Primary Care Setting" Nurse Practitioner, #14, 1989, pp. 47-55.

4. Commonwealth Fund Report, 1999.

5. Gazmariaian, et al "Violence Against Women, Family Planning and Pregnancy" in Maternal and Child Health Special Issues: Violence and Family Planning Conference Proceedings, 1999. MCH Clearing House.

6. Washington State Behavioral Risk Factor Surveillance System. A telephone survey supported by Washington State Department of Health in collaboration with the Centers for Disease Control and Prevention that collects information about personal behavior and health practices from English speaking adults 18 years and over in Washington State in households with telephones. 2000.

7. Pregnancy Risk Assessment Monitoring System. An ongoing population based surveillance system sponsored by the Centers for Disease Control and Prevention that surveys new mothers who are representative of all registered births to Washington State residents, 2000.

8. Washington State Coalition Against Domestic Violence "Tell the world what happened to me…" Findings and Recommendations from the Washington State Domestic Violence Fatality Review, December 2002.

# Appendix A

# PPADV Assessment Tool and Question Guide

# PPADV ASSESSMENT TOOL

Agency: _____ Assessor: _____ Date:_____

(1) Score each question in each box with a 1 for YES and a 0 For No. (2) Please note that N/A means not applicable – Do Not Score. (3) See question guide to assist in clarification.

| Questions/Targets | INTERNAL | | EXTERNAL | | Totals |
|---|---|---|---|---|---|
| | Staff | Administration | Community | Domestic Violence Service Providers | |
| ***Predisposing*** | | | | | |
| 1. Is there a basic level of knowledge about domestic violence and culturally relevant domestic violence resources? | | | | | |
| 2. Are attitudes supportive to domestic violence activities? | | | | | |
| **Totals:** | | | | | |
| ***Enabling*** | | | | | |
| 3. Is sufficient funding available? | | | | | |
| 4. Are formal and informal power structures supportive of domestic violence activities? | | | | | |
| 5. Can the decision-making processes be influenced in support of domestic violence activities? | | | | | |
| 6. Are staff skilled and culturally competent, regarding domestic violence, for the population served? | | | N/A | | |
| 7. Are agency policies (protocols) sufficient to provide effective, culturally relevant service? | | | N/A | | |
| 8. Is there sufficient capacity (staff/time) and resources (trainers, consultants, services, advocates) to provide effective, culturally relevant services? | | | N/A | | |
| 9. Are there effective relationships in place to promote and provide effective, culturally relevant services? | | | | | |
| **Totals:** | | | | | |
| ***Reinforcing*** | | | | | |
| 10. Do patients experiencing domestic violence report feeling supported, respected for their choices and that services were culturally relevant to their situation? | | | | | |
| 11. Are there meaningful incentives/recognition for providing culturally relevant care for victims of domestic violence? | | | | | |
| **Totals:** | | | | | |
| **Grand Total:** | | | | | |

# Assessment Question Guide

For each assessment question this section will provide a brief comment on the topic area and a series of questions that will assist the assessor in making a judgment about the scoring of the question for each target group. These questions can be used to develop interviews, focus groups or written surveys for each of the target groups. The second section is titled "Activities to Address this Issue". This section will provide information from the PPADV - ICHS Domestic Violence Project that might be of use in developing the targeted plan.

## Question 1 - **Predisposing**

Is there a basic level of knowledge about domestic violence and domestic violence resources?

It is critical that each target group have a basic level of knowledge about domestic violence and the domestic violence resources in the community. The basic level of information will be different for each target group. Please keep the following ideas in mind when assessing this area.

### Agency Staff

- Do all staff know the basic definition for domestic violence?
- Do all provider staff know the behavioral cues of violence? These cues are: poor sleep, poor management of chronic health issues, visible physical injuries, location of physical injuries, evidence of sexual assault, change in or multiple missed clinic visits, low compliance with recommendations, the partner controls all interactions with clinic staff, observation of partner threats or anger toward patient, visits for vague somatic complaints, addictions, patient reports partner controls food, money or access to basic necessities and/or immigration assistance
- Do all staff have knowledge of resources? Examples of resources are: domestic violence advocacy, housing, immigration and other legal services. This knowledge should be reflected in agency training materials, written resource materials, policies and the providers being able to tell the assessor about specific resources used.

### Agency Administration

- Do all agency administration staff know the basic definition of domestic violence?
- Do all agency board members, managers and directors know the impact of domestic violence on patient health and the costs to the agency for Domestic Violence related health problems?
- Do all administration managers and directors know that some employees are experiencing domestic violence and how to respond?
- Do administration managers, directors and board members know how domestic violence impacts the patients being served by the clinic?

- Do all agency administration staff have knowledge of one or two culturally relevant Domestic Violence resources?

### Community Served

- Do most patients and community members know the basic definition of domestic violence?
- Do community leaders know how domestic violence impacts the health of women, children and families?
- Do patients and most community members know of resources for domestic violence?

### Domestic Violence Service Providers

- Do domestic violence service providers have knowledge of the cultural groups in the community in relation to the definition of domestic violence?
- Do domestic violence service providers have bicultural/bilingual staff or access to confidential interpretive services?
- Do domestic violence service providers have knowledge of the medical systems in the community and their role in relation to domestic violence?
- Do the domestic violence service providers have support groups/services for culturally diverse patients?

## Question 2 - **Predisposing**

Are attitudes about domestic violence supportive to domestic violence activities?

Attitudes are affected by values, beliefs and past experiences. This question does not focus on judging the attitudes of staff, agency administration, the community served or domestic violence service providers. The focus is on knowing what the attitudes are and how they will impact the development and implementation of domestic violence activities.

### Agency Staff

There will be differences in attitudes based on age, gender, country of origin, religious affiliation, personal experience and experience with patients.

- Does agency staff believe that although domestic violence is a private family matter it must be discussed?
- Do agency providers/interpreters feel comfortable when asking about or discussing domestic violence?
- Does staff feel that patients would feel cared about if they are asked about domestic violence?
- Does staff feel that referral to domestic violence resources will improve family relationships?
- Does staff feel safe in the agency setting when the perpetrator is present?

- Does staff feel that domestic violence is not tolerated by any cultural group?
- Does staff feel that domestic violence is as critical an issue as other health concerns for patients?

### Agency Administration

- Do individual members of the board, the directors and/or managers view domestic violence as an issue that does have a significant health impact the community or the clinic?
- Do members of the board, directors and/or managers feel that the clinic has a role in the community response to domestic violence?
- Do managers feel that domestic violence is "one of the most important" issues facing the patient population?
- Does administration staff feel that there is not a risk to staff safety in asking about domestic violence?
- Does administration feel that providing domestic violence services would not take up too much provider time and therefore not reduce clinic income?

### Community Served

- Do community members or leaders feel that there is no shame in domestic violence?
- Do community members feel that the victim is not to blame for abuse?
- Do community members feel that alcohol or drugs or stress do not cause abuse?
- Do community members feel domestic violence resources respect their culture?
- Do all members of the community feel they have a role in preventing domestic violence?

### Domestic Violence Service Providers

- Do domestic violence service providers support that medical providers have a role in the community response to domestic violence?
- Do domestic violence service providers support and understand the cultural differences regarding domestic violence?

## Question 3 - **Enabling**

Is sufficient funding available?

The following guidelines provide suggestions for exploring all options for funding.

### Agency Staff

- Can domestic violence services be reimbursed from direct billing (insurance, First Steps) for provider time? Look at billing instructions from these sources.
- Are any of the services provided eligible for existing grant fund within the clinic?

## Agency Administration

- Can current clinic financial conditions provide funding for domestic violence activities?
- Is there discretionary money available for new programs?
- Are cutbacks expected at the current time?
- Does your agency have funding/in-kind resources for domestic violence activities?
- Are there no other initiatives in the clinic at this time that take away the funding and resources for domestic violence activities?
- Are there grant funds that could be available?
- Are there time and personnel to write grants?

## Community Served

- Are there any programs, benefactors, sponsors or grants within the community that could contribute funding for the domestic violence activities?
- Are there in-kind community resources that could be used?

## Domestic Violence Service Providers

- Do the local domestic violence service providers have sufficient funding for the domestic violence activities?
- Are these agencies facing cuts in staff, activities or resources?

# Question 4 - **Enabling**

Are formal and informal power structures in support of domestic violence activities?

Within each of the target groups, there are formal and informal power structures that must be considered in the assessment phase. Formal power structures are official sources of power and include: directors, board chairs, supervisors, managers, and community religious and political leaders. Informal power structures can be very influential but do not have a title or formal designation. These might include individuals or clusters of individuals, who: are highly skilled/knowledgeable, have access to information, hold positions that can facilitate or restrict change, provide social emotional support and are informal communication leaders within a specific cultural group.

## Agency Staff

- Can you identify all of the informal power structures within the clinic staff?
- Are these informal power structures supportive of domestic violence activities? If so, what activities?
- Is the level of support from each of the informal power structures strong (willing to be a advocate) for specific domestic violence activities?
- Can neutral or negative support from informal power structures be modified?

## Agency Administration

- Are champions for domestic violence activities within the formal power structure of the clinic?
- Is there a consistent level of support from the formal power structure across all levels (managers, directors and board members) for domestic violence activities?
- Can neutral or negative support from the formal power structure be modified?
- Does the formal power structure influence clinical change?

## Community Served

There will be a mixture of formal and informal power structures in the community. The religious leader may have the formal power but that leaders' spouse may be the informal social leader within a given group. Both need to be considered in scoring this item.

Is there strong support within the formal or informal power structures of the community for domestic violence activities?

- Can neutral or negative support be influenced?

## Domestic Violence Service Providers

- Does the formal power structure have strong support for the clinic to have a role in a community response to domestic violence?
- Does the informal power structure have strong support for the clinic to have a role in a community response to domestic violence?
- Can neutral or negative support in either the informal or formal power structure be influenced?

# Question 5 - **Enabling**

Can the decision-making processes be influenced in support of domestic violence activities?

The process of deciding which issue will get the scarce resources is a challenge. Each community clinic, each Domestic Violence agency and community group must make decisions based on their mission, funding, staffing and the health of the community served. Decision-making will be based on the needs of the total community from a leadership position. Assessment of this issue will take the form of asking many different questions about the decision-making process NOT about domestic violence.

## Agency Staff

- Can provider decisions to participate in domestic violence activities be influenced?
- Can provider buy-in be established to develop domestic violence activities?
- Can non-medical staff decisions to participate in domestic violence activities be influenced?

## Agency Administration

- Are there new initiatives (like the Diabetes Collaborative) that will be required of the clinic by funders within the next 2 years?
- Can administration decisions in regard to domestic violence activities be influenced?
- What kind of information is required to make decisions regarding the start of new clinic initiatives?
- Can the main decision makers in the agency be identified? Are they open to influence?
- Can the influence from the community served be identified?

## Community Served

The community is affected by a wide variety of influences: immigration policies, the economic circumstances of the population, the language level of the community (monolingual, bilingual, multilingual), the level of acculturation, the value system of the culture, the religious practices and the growth of the population. The community can have significant impact on clinic services and clinic services will impact the community.

- Can the major influences supportive of domestic violence activities be identified?
- Can the decision-making process within the community be identified?
- Can the clinic have influence on this process?

## Domestic Violence Service Providers

- Does anyone in your agency know individuals in the domestic violence agency?
- How are decisions made in the agency?
- What are the pressures that influence those decisions?
- Can these decisions be influenced?
- Who makes the decisions?

# Question 6 - **Enabling**

Are staff, skilled and culturally competent regarding domestic violence, for the population served?

This is a multi-faceted question that applies to the clinic staff and the community agency service providers. In order for domestic violence activities to be successful the clinic, the community and the service providers must be culturally competent and skilled in the methods of identification, referral, assessment and safety planning. Please note that the term staff includes interpreters, professionals, paraprofessionals and office staff. The assessment of the skill level will be systemic not individualized.

## Agency Staff

Assessment of this area can be based on direct observation, review of case records, interviews with staff and training records.

- Do all staff have the ability to observe some or all of the behavioral "cues" listed under question #1?
- Do providers have the ability to interview about the behavioral "cues"?
- Do all staff have the ability to interpret patient information in a cultural framework that matches the patient's frame of reference?
- Do all staff know when and where to refer when greater expertise is required to serve the patient experiencing domestic violence?
- Do a sample of case records demonstrate that provider staff know how to document domestic violence issues?
- Do all staff have the ability to respond to patient questions about domestic violence materials that are displayed within the clinic?

### Agency Administration

- Are managers trained sufficiently to supervise staff on domestic violence activities?
- What is their ability to monitor the work being completed?
- Do managers have an orientation program for new staff on domestic violence activities in the clinic?

### Community Served: Not Applicable

### Domestic Violence Service Providers

- Can the methods of service provision from domestic violence service providers be identified?
- Does the domestic violence agency in your area provide: legal advocacy services, advocacy counseling, and housing options?
- Does the domestic violence provider agency provide culturally sensitive and relevant services (bilingual/bicultural advocates with the ability to relate to all members of the community)?

## Question 7 - **Enabling**

Are agency policies (protocols, safety, risk management) sufficient to provide effective, culturally relevant service?

This question is directed at what are the formal written and informal policies in the community clinic and the domestic violence service provider agencies.

### Agency Staff

There are several clinical tools that have been recommended for use with patients in primary care settings. Frequently, clinic providers bring in tools they are familiar with and used them instead of those recommended by the protocol. It is important to know the number of tools being used, if they are recommended tools or tools that have been adapted from experience or over time with various cultural groups. It is critical that you find out what is in most

prevalent use in the clinic and by whom. This will allow you to find out the preferences of the clinic staff.

Questions can be divided into two areas:

1. Protocols

   If a written domestic violence protocol exists:

   - Does staff know what it says?
   - Does staff follow the protocol? Do they agree with it? Is there buy in?
   - Is it easy to understand?
   - Is it easy to implement?
   - Is it flexible enough for all populations served?
   - Is there a method to change it based on experience?

   If no protocol exists:

   - Are there informal services for domestic violence identification and referral?
   - Do staff see the need for a protocol?

2. Tools

   If tools exist:

   - Are they easy to understand?
   - Are they easy to administer? (single dedicated tool or integrated questions)
   - Is it flexible enough to be relevant to patients of diverse ethnic groups who are served?
   - Is there buy in from agency staff?
   - Does it fit with existing clinic practices?
   - Is there a way to keep it confidential with ease?

     (Survivors of domestic violence report that their partners are very good at gaining access to "confidential records.")
   - Can this agency guarantee confidentiality?

   If tools do not exist:

   - Is anything used to identify domestic violence?
   - Is anything used to document?

## Agency Administration

This is a general question regarding the more formal WRITTEN and monitored aspects of clinical policies within the community clinic. In order to find the written elements:

Is there a written protocol? If yes:

- Is management team aware of it?
- Is it board approved?
- Has it been reviewed by agency risk management and the agency insurance carrier?
- Is there a manager responsible for implementation?
- Is there monitoring for this protocol?
- Are there consequences for no compliance to the protocol?
- Is confidentiality protected?

If no:

- Are there elements in the clinic safety policies, workplace violence policies, mandatory Child Abuse Reporting policies, records management and confidentiality policies?
- Is there a manager responsible for developing a protocol?

Is there a clinic screening tool(s) for domestic violence?

- Has the board approved them?
- Has management team approved them?
- Is tool use monitored?
- Is confidentiality protected?
- Is there a manager assigned to follow up?
- Are there consequences for not using the tool?

### Community Served: Not Applicable

### Domestic Violence Service Providers

- Do domestic violence service providers have a copy or knowledge of the clinic protocol?
- Is there a written procedure of how the domestic violence service provider handles referrals, requests for training or consultation?
- Do the clinic procedures or protocols coordinate with the domestic violence service provider procedures?
- Is there a clear procedure on referrals and confidentiality?

## Question 8 - **Enabling**

Is there sufficient capacity (staff, time) and resources (trainers, consultants, advocates) to provide effective, culturally relevant services?

This is a critical question for agency staff, agency administration and domestic violence service providers. No matter what the domestic violence activity there must be a commitment to sustain a level of staff and resources to assure that it occurs. Within both the PPADV - ICHS Project Community Clinic and domestic violence service providers, the

most critical element to successful activities was staff time. The assessor must have clarity regarding the capacity needed by the domestic violence activities. Ask questions accordingly.

### Agency staff

- Is there a specific amount of time allowed for a prenatal visit with:
    - the medical provider
    - First Steps staff
    - the interpreter or medical assistant
    - office staff
- Is there a safe, private space available for patient to be interviewed?
- Does the amount of time provide for a "comfortable" fit for domestic violence activities?
- If relationship is needed to ask sensitive questions how can time be modified?
- Are there other ways to use staff time to help with identification of domestic violence?

### Agency Administration

- Does the agency have the capacity to do and maintain the domestic violence activity?
- Are there additional resources to support domestic violence activities such as (clerical skills for record keeping, training, trainer availability, consultation and individual support) for agency staff to support domestic violence activity?

### Community Served: Not Applicable

### Domestic Violence Service Providers

- Do domestic violence service providers have staff time available to consult with clinic staff or assist patients from the clinic who need referral?
- Is there sufficient time for domestic violence service providers to increase caseloads should referrals increase?

## Question 9 - **Enabling**

Are there effective relationships in place to promote and provide effective, coordinated, culturally relevant services?

Relationship is key to providing services to victims of domestic violence during pregnancy and postpartum. In the PPADV - ICHS Project prenatal patients and survivors reported if they could trust their health care provider they would disclose abuse. Providers indicated that if their patients trusted them they would feel more like asking about abuse. The issue of trust extended to providers trusting referrals to domestic violence service providers.

### Agency Staff

- Can providers form effective relationships with patients in this clinical setting?

- Are there the resources to support relationship building with patients?
- Do providers report feeling effective with patients experiencing domestic violence?
- Are there effective relationships between clinic managers and provider staff?
- Are there effective relationships between provider staff and resources for domestic violence services?
- Is there training or mentoring for the new providers to a system within the clinic?
- Is there mentoring for all staff on complex issues or cultural challenges?

## Agency Administration

- Are there effective relationships between agency staff and managers?
- Are there methods to capture patient satisfaction with agency service providers? Is this information used?
- Are there effective relationships between agency administration and domestic violence service agencies?
- Are there mechanisms in place to foster relationship building with the community, patients, within the agency and outside of it?
- Are community board members actively relating to clinic staff?

## Community Served

- Does the community view the community clinic a good partner?
- Is there positive regard for the community clinic?
- Does the community view the clinic as a safe place?

## Domestic Violence Service Providers

- Do domestic violence service providers have positive regard for the community served?
- Do domestic violence service providers feel accepted by the community and the clinic?
- Are there cooperative agreements between the community clinic and the domestic violence agencies?
- Is there general feedback to the clinic on the status of cases?
- What mechanisms are in place to provide a feedback loop between providers and advocates?

## Question 10 - **Reinforcing**

Do patients, experiencing domestic violence, report feeling supported, respected for their choices and that services provided were culturally relevant to their situation?

### All Target Groups

Each target group has their own method of collecting information about patient satisfaction and the helpfulness of the agencies. In most instances this information will be word of mouth not written on a survey form. Interviews with key informants will gain a picture of this issue.

- Do patients report that they feel supported and respected when domestic violence is indicated?
- Do patients feel the domestic violence services obtained from the clinic were relevant and useful?
- Do all providers work with patients experiencing domestic violence?

## Question 11 - **Reinforcing**

Are there meaningful incentives/recognition for staff who provide culturally relevant care for victims of domestic violence?

The PPADV - ICHS Project noted that incentives, recognition and feedback about the project activities were most important to agency staff, administration, and domestic violence providers. This kind of feedback and recognition reinforces provider behavior.

### Agency Staff

- Are there staff recognition events? Does staff attend and enjoy staff recognition activities?
- Are staff provided information about individual successes with clinical practices?
- Can you list a number of methods that staff would like to be recognized for their efforts?
- Are there opportunities to give incentives to providers for work well done (time off, gift certificates)?

### Agency Administration

At this level in the agency, it is important that the services provided lower costs, increase services to patients, and that there is data showing that the patient population has reduced risk for further health issues. These are incentives to keep the domestic violence activities continuing.

- Are there methods to track the cost of a domestic violence activity?
- Are there ways to provide feedback from patients to agency administration?

## Community Served

Incentives from a community perspective will be lower health care costs, less traumatized families and better birth outcomes. The community may feel respect and gain recognition for working together to support the domestic violence activity.

- Are there methods to capture community satisfaction with clinic domestic violence activities?

## Domestic Violence Service Providers

Increased referrals, patients who feel supported and working relationships with health care settings are reinforcing for domestic violence service providers. Recognition for the coordinated effort and services provided to diverse patients is reinforcing as well.

- Are there methods to capture the number of referrals from the clinic?
- Are there safe methods to capture "stories" from survivors that can be shared with the clinic?

# Appendix B

## Targeted Plan Form and Suggested Activities

# Targeted Plan Form For Domestic Violence Identification Activities

Assessor/Implementer: Date:

| Activities/Target | Staff | Administration | Community | Domestic Violence Service Providers |
|---|---|---|---|---|
| ***Predisposing*** | | | | |
| Knowledge | | | | |
| Attitudes | | | | |
| ***Enabling*** | | | | |
| Power Sources | | | | |
| Decision Making | | | | |
| Staff Skills | | | | |
| Resources | | | | |
| Effective Relationships | | | | |
| ***Reinforcing*** | | | | |
| Patient Satisfaction | | | | |
| Provider Incentive | | | | |

# Suggested Activities

The following suggestions were developed to address barriers for the PPADV - ICHS Domestic Violence Project. These same activities could be used to reinforce strengths as well.

## Activities By Factor/Question

### Predisposing Factors

#### Question #1 Is there a basic level of knowledge about domestic violence and domestic violence resources?

#### Question #2 Are attitudes supportive to domestic violence activities?

Agency Staff: There can be a variety of ways to increase staff knowledge and help to modify attitudes. The following ideas can be implemented easily:

1. Training:

   Formal

   - Use the PPADV Curriculum with the local domestic violence service provider to provide training on a specific issue that is impacting the clinic staff such as sexual assault.
   - Target in-service case consultations about domestic violence issues that are of interest to medical staff, front desk staff or interpreters on items such as clinical cues of domestic violence, how victims feel when asked about violence or myths and facts about domestic violence for the cultural groups we serve.

   Informal

   - Circulate Provider Fact Sheets from Appendix 2 Training section as needed for providers.
   - Ask domestic violence service providers to come at lunch hours to discuss issues with staff.
   - Use opportunities to promote knowledge when an incident of domestic violence is in the news.
   - Present resource sheet or brochures from community based domestic violence service providers to all staff.

2. Use the Fact or Myth Game with the entire clinic to stimulate discussion and increase knowledge.

   Agency Administration

   - Consider having a presentation of "In Her Shoes" an informational game about domestic violence that can be presented by domestic violence advocate staff.

- Provide a brief presentation (using Provider Fact Sheets) to the agency board members about the impact of domestic violence on service provision in the agency using statistics from your own agency.
- Work with administration (Risk Management, Safety Committee, or Human Resources) on services provided to staff experiencing domestic violence.

Community

- Use the patient brochure in Appendix D to inform community leaders about the issue of domestic violence during pregnancy.
- Offer the restroom materials in Appendix 2 to community churches or social organizations for use.
- Have agency staff provide presentations on domestic violence and it's impact on the health of the pregnant/postpartum patient and the infant.

Domestic Violence Agencies

- Set up a time to meet with the domestic violence service providers to regarding the population in the clinic and how they are served in the community.
- Establish a "lunch" presentation or invite local domestic violence advocates to a staff meeting to give them more information about perinatal services and the importance of good medical care for women experiencing violence and pregnancy.

## Enabling Factors

### Question #3: Is sufficient funding available?

Agency Staff

- Locate funding for domestic violence activities in agency by looking to current program services, community service groups and local foundations to support small projects.
- Request that clinic management provide funds for a small educational project (i.e. rest room materials or patient brochures) that will cost less than $500.00.

Agency Administration

- Integrate materials on domestic violence into existing systems whenever possible.
- Interview management for information on sources of existing funding that could cover domestic violence activities.

Community

- Contact community leaders to find out about funding that is available to specific community groups for services.
- Discuss the issue of funding with service groups within the community to find sources of funding or in-kind support.

Domestic Violence Service Providers

- Convene a workgroup with community-based agencies to discuss the need for funding.
- Develop a plan with domestic violence service providers to apply for funding for a specific project on domestic violence and pregnancy.

### Question #4: Are formal and informal power structures in support of domestic violence activities?

and

### Question #5: Can decision-making processes be influenced to be supportive of domestic violence activities?

Agency Staff

- Interview the medical director and clinic director regarding the lack of support for domestic violence activities.
- Identify the informal power system within the staff and interview them regarding their level of support for domestic violence activities.
- Identify the decision making process used by providers and non- medical staff regarding the inclusion or exclusion of domestic violence activities. Locate methods to influence it.

Agency Administration

- Interview the executive director regarding the lack of support for domestic violence activities.
- Have a conversation with the agency manager on ways to address objections to domestic violence activities or ways to promote conversation on the subject.

Community

- Identify the reasons for a lack of support by community leaders for domestic violence activities.
- Identify the reasons for a lack of support by the women in the community regarding domestic violence activities.

Domestic Violence Service Providers

- Work with domestic violence service providers to develop a plan for addressing the barriers to domestic violence activities in the clinic and community.

### Question #6: Are there staff that are skilled and culturally competent in the area of domestic violence for the population served?

Agency Staff

- Use the Fact and Myth format to assess staff skill and cultural competency about domestic violence. Then develop a simple training plan for the year on the knowledge gaps.
- Send out Provider Fact Sheets on specific topics through out the year.
- Review charts and gather more information on how staff skills are translated into patient charts. Use this information to further address training needs.

Agency Administration

- Discuss with administration issues related to agency obligations to address staff competence regarding domestic violence. Share information on expectations.
- Share basic information on minimum competence of interpreters regarding domestic violence.

Domestic Violence Service Providers

- Discuss with domestic violence service providers the methods they use for assessing cultural competency in relation to domestic violence.

### Question #7: Are agency policies sufficient to provide effective, culturally relevant service?

Agency staff

- Review the questions in the Assessment Question Guide of Appendix A regarding the agency protocols and tools. Based on this review develop activities to address the gaps.
- Develop a workgroup with staff to review protocols and tools to make them more streamlined and useful.

Agency Administration

- Review the agency safety policy to assure that there are policies for safety from workplace violence.
- Review domestic violence materials with management.

Domestic Violence Service Agencies

- Gain a copy of the protocols for domestic violence service agencies regarding their handling of referrals and service provision. Share with clinic staff.
- Review materials on advocacy counseling. Share with staff.

### Question #8: Is there sufficient capacity (staff) and resources to provider effective, culturally relevant service?

Agency Staff

- Determine an adequate level of staff capacity to complete prenatal work activities.

- Develop a small prenatal workgroup with staff to find ways to make domestic violence services more efficient and effective.

Agency Administration

Domestic Violence Service Providers

### Question #9: Are there effective relationships in place to promote and provide effective, culturally relevant services?

Agency Staff

- Promote relationships between staff and patients by increasing the knowledge level of staff and patients about domestic violence.
- Provide informational meetings on cultivating relationships between patients and staff that will allow for promoting more effective services on domestic violence.

Agency Administration

- Assure that there is an Employee Assistance Program that is sensitive to domestic violence issues.
- Build relationships with board members regarding how the clinic can support services for domestic violence.

Community

- Provide a Domestic Violence and Health Information Fair for community and service providers with booths, information packets and materials available.
- Train and support provider staff to give short presentations on how family violence affects the health status of mothers and infants in the community.

Domestic Violence Service Providers

- Hold "brown bag" case conference sessions with the local domestic violence service providers related to domestic violence.
- Request assistance from local domestic violence service providers on developing tools, resource lists and materials for the clinic.

## Reinforcing Factors

### Question #10: Do patients experiencing domestic violence report feeling supported, respected for their choices and that services were culturally relevant to their situation?

Agency Staff

- During case staffings, interview staff regarding comments they hear from patients who have been served by the agency for domestic violence issues.
- During informal meetings, interview staff that represent specific cultures and ask about their perception of the services provided in the clinic.

Agency Administration

- As part of quality assurance, include questions about domestic violence services into consumer satisfaction questionnaires.
- Develop methods for capturing comments from patients on services provided for domestic violence issues (suggestion box, or interviews with interpreters, outreach workers, and paraprofessionals who are members of the community).

Community

- Check in with community leaders to discuss feedback regarding services from the clinic on domestic violence.
- Include a question in the clinic consumer satisfaction materials on how domestic violence services are received.

Domestic Violence Service Providers

- Interview domestic violence service providers on the feedback they have received from survivors regarding clinic management of domestic violence issues.

### Question #11:Are there incentives/recognition for providing culturally relevant care for victims of domestic violence?

Agency Staff

- Use information from assessment to develop incentives that will work for providers to increase their domestic violence identification activities.
- Hold recognition events for staff that are supportive of domestic violence activities.

Agency Administration

- Encourage support of domestic violence activities through specific incentives.

Community

- Work with community to develop acknowledgements of clinic staff that support domestic violence activities.

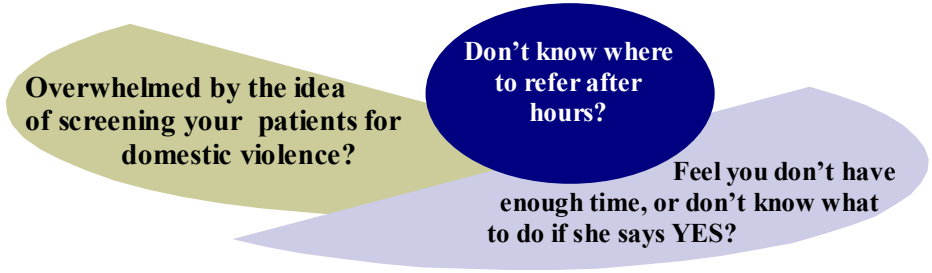
# Appendix C

## Provider Fact Sheets

# 60 – Second Domestic Violence Intervention in a Health Care Setting / 24-Hour Resources

## *Ask the question:*

- ASKING about domestic violence is an intervention in and of itself. It takes less than one minute and lets your patient know you take the issue seriously.
- For client safety, be sure to ask when the patient is ALONE or with an interpreter she feels safe with.




## *Ask in a way that is comfortable to you:*

- YOU choose how to ask your patient. Statements prior to the question "frame" why you are asking the question. Some options are:
- Our clinic policy is to ask all female patients about domestic violence because it is so common. Or, I find many women in my practice have experienced hitting or verbal threats, so I ask everyone about this during an exam.
- Have you ever experienced abuse (being physically hurt, or emotionally hurt) in your relationship?
- People often report feeling stress at home. How do you and your partner deal with stress?
- Do you ever feel controlled by your partner?
- I'm concerned your bruise was caused by your partner. Has s/he been hurting you?

## *If your patient says NO:*

- Tell her you are glad she is not experiencing violence right now.
- Give her a business card or brochure for a Domestic Violence agency and tell her she can call if she or anyone she knows ever experiences abuse in a relationship.

## *If your patient says YES:*

- Acknowledge that you heard your patient. Be non-judgmental.
- Safety first: Ask – Is it safe to go home today? Do you have a plan for escape if needed? If she says YES or NO you can suggest that she could call the Washington State Domestic Violence Hotline from a private place in your office to gain contact with an advocate who can help her with safety issues.
- Reach out: for an immediate service response and safety planning for your client. For 24-hour resources that have access to interpreter services for monolingual women see next section.
- Document: record physical signs of abuse and what she says in her chart. – Assure that records are confidential.
- Follow up: check back with the patient at a later date to assure a linkage to support has been made.

## *24-hour resources for patients*

Washington State Domestic Violence Hotline 1-800-562-6025 (V/TTY)

## *Other Tools*

- Have posters and brochures about Domestic Violence in your office lobby and bathrooms (the victim may not feel comfortable disclosing directly to you).
- Make Domestic Violence screening a routine part of your health examination.

# Provider Guide to Domestic Violence Screening Questions

- While screening, you can increase your patient's comfort by framing your screening questions with:
- "It's ICHS clinic policy to screen all patients for Domestic Violence during pregnancy and postpartum visits"
- "Many women experience domestic violence, so I ask all my patients these questions"
- Remind her of the confidentiality of your questions.
- Continue with one or both of the following methods outlined in the table.
- If you suspect abuse, but your patient denies it, honor her decision to not discuss the issue and if safe and appropriate, provide her with a Domestic Violence Safety Card. *The cards can be ordered at* http://www.prt.wa.gov/ *Click on the General Store icon; then enter your registration information, click on "shop by agency," select the Department of Social and Health Services, select Economic Services Administration; then select General Economic Services – then find and select form number 22-276X (or select your required language version).*

## General Screening Questions

*Designed to identify women who might be experiencing violence, but have no physical evidence of violence.*

| Direct Method | Indirect Method |
|---|---|
| ✓ "Have you ever been or are you now being hit/slapped/kicked/ pushed/physically hurt? Who is/was it?" | ✓ "You mentioned that your partner loses his temper with the children. Can you elaborate on that? Has he ever hit or threatened to hit you or your children?" |
| ✓ "Has your partner ever forced you to have sex when you didn't want to? Has he ever refused to practice safe sex?" | ✓ "You seem concerned about your partner. Does he act in ways that frighten you?" |
| ✓ "Does your partner ever try to control you by threatening to hurt you or your family?" | ✓ "How do you and your partner deal with conflicts/differences? What happens when you disagree? What happens when your partner doesn't get his way?" |
| ✓ "Do you ever feel afraid of your partner? Do you feel you are in danger? Is it safe for you to go home?" | ✓ "You mentioned that your partner uses alcohol. How does he act when he is intoxicated? Does his behavior ever frighten you? Does he ever become violent?" |

## Injury Screening Questions

*Designed for use when you have observed physical injury that you suspect is caused by violence by another person.*

| Direct Method | Indirect Method |
|---|---|
| ✓ "I'm concerned that your symptoms may have been caused by someone hurting you. Has someone been hurting you?" | ✓ "Have you been under stress lately? Are you having problems with your partner? Do you ever argue/fight? Have these fights become violent? Have you gotten hurt?" |
| ✓ "Have you experienced uncomfortable touching or been forced to have sexual contact?" | ✓ "How are things going in your relationship? All couples argue sometimes. Are you having fights? Do you fight physically? Does he touch you in ways that frighten you?" |

*If the patient answers "yes" to any of your screening questions or shares any Domestic Violence experience with you, you may continue with the Assessment and Safety Planning—or refer your patient to _____*(insert name)*_____. ALWAYS ASK FOR PERMISSION BEFORE SHARING ANY OF THE PATIENT'S DISCLOSED AND PERSONAL INFORMATION TO REFERRAL SOURCES.

# Provider Guide: What Is Sexual Assault?

Any unwanted sexual contact or attention, whether by force or manipulation, including incest, rape (oral, anal, and/or vaginal penetration with or without the use of objects), sexual harassment, forced prostitution, and forced pornography.

- In nearly 3 out of 4 incidences of sexual assault, the offender is an intimate current or former partner/spouse, family member, or an acquaintance (U.S. Department of Justice).
- Approximately 99% of perpetrators are male, and 91% of victims are female.

## Does Sexual Assault Occur in Intimate Partner Relationships?

Despite under-reporting, approximately 10-14% of married women experience rape/sexual assault in marriage.

- Sexual assault can take place in all types of intimate partner relationships regardless of social class, sexual orientation, age, religion, disability status, race or ethnicity.
- Estimates indicate that 52% of all Asian women have been physically or sexually assaulted in their lifetime (The National Violence Against Women Survey; 1998).
- Sexual assault also occurs in same-sex relationships. In a nation-wide survey, 41% of lesbians reported being raped or sexually abused. Perpetrators may be past/present male partners, female partners, or strangers.
- Women who are physically battered by their spouse are more likely to be sexually assaulted by their spouse.
- Women who are sexually assaulted by their spouse are more likely to experience multiple assaults.
- Women who are pregnant are at a higher risk for violence (physical and sexual).
- Women who are physically or mentally vulnerable, ill or disabled are also at a greater risk for violence, as are women who are separated or divorced.

## What Are the Physical & Emotional Consequences of Sexual Assault?

There are severe short and long-term consequences associated with sexual assault including:

| PHYSICAL | EMOTIONAL |
|---|---|
| ▪ Cuts, soreness, bruising, torn muscles, vaginismus (involuntary contraction of the vaginal muscles), fatigue, and vomiting.<br>▪ Frequent assaults may result in broken bones, black eyes, bloody noses, and knife wounds.<br>▪ Sexual attacks may lead to vaginal stretching, miscarriage, infections (bladder and vaginal), sexually transmitted diseases, and infertility. | ▪ Post Traumatic Stress Disorder, depression, anxiety, intense fear, suicidal ideation, and distress or jumpiness when touched.<br>▪ Sleep disorders, eating disorders, negative self-image, and sexual dysfunction.<br>▪ Emotional symptoms may coincide with or without physical evidence. |

## Clinical Considerations

- Feelings of shame, self-blame, fear, and upholding traditional views of doing 'wifely duties,' may lead to a delay or avoidance of seeking medical care.
- Clinicians can play a significant role in challenging sexual assault tolerance and myths by:
- Paying attention to signs of abuse (outlined above) and screening for sexual violence in a culturally appropriate manner, i.e. using the client's first language when appropriate and framing questions so that they are not invasive/intrusive.
- Providing culturally appropriate support and understanding.
- Questioning assumptions and biases of their own.

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Tjaden, P., Thoennes, P. (1998). Prevalence, incidents, and Consequences of Violence Against Women: Findings from the NVAW Survey. Washington DC: National Institute of Justice and Centers for Disease Control and Prevention

# Mandated Reporting Requirements For Child and Vulnerable Adult Abuse in Washington State

## Required Reporting

When screening for domestic violence, you may hear about the abuse of children and/or vulnerable adults (adults age 18 and above; adults with disabilities; and/or seniors who are receiving services from an individual for their care [personal aid] RCW 74.34.021). When this happens, you are required by law to report the abuse to Child Protective Services (CPS) or to Adult Protective Services (APS). You are not responsible to prove or otherwise investigate the issue. You are responsible to report to authorities within 24 hours. It is important to make these reports in a way that will honor your relationship with your patient and will not put the individuals concerned in further danger. If in doubt, call for consultation at the numbers below.

## Ways to Report

1. Be sure you tell your patient as soon as possible that you are a mandatory reporter. Statements about required reporting should be contained in all medical care consent forms (in the confidentiality section). It is your responsibility to ensure your patient understands this requirement.

2. When a report must be made, ask the patient to make the report him/herself, with your support. For example: "I am required to report suspected abuse to Child Protective Services (like when you told me your husband is leaving bruises on both of the boys). In my experience, it is better if you report the abuse to CPS with me here to support you. Let's do this together. I have the number right here and it should take just a few minutes." This allows the patient to feel supported and lets CPS know s/he is concerned about the welfare of the children.

3. Use a phone that is in a quiet, private area where the patient can talk without disturbance or being overheard by others.

## Contact Phone Numbers

| | | | |
|---|---|---|---|
| **Child Protective Services** | **206-721-6500** | **(24-Hours)** | **V/TTY** |
| **Adult Protective Services** | **800-346-9257** | **(24-Hours)** | **V/TTY** |

Please call these numbers IF YOU HAVE questions and/or concerns.

## PROVIDER GUIDE: DOCUMENTING SUSPECTED/DISCLOSED DOMESTIC VIOLENCE

***Medical Documentation*:** Comprehensive, well-documented medical records are essential for the prevention of further abuse and for providing concrete evidence in any legal case. Complete a legible medical record for each known or suspected victim of intimate partner violence. Include the following information:

| | If Patient Acknowledges Abuse or is Being Seen for Domestic Violence-Related Injuries | If Patient Denies Abuse; Provider suspects Abuse |
|---|---|---|
| **Include in the chart** | 1. The main complaint as well as details of what happened.<br>2. Any previous abuse episodes.<br>3. The perpetrator's name.<br>4. The patient's relationship to the perpetrator at the time of injury.<br>5. The date and location of abuse/injury.<br>6. Type, number, size, and location of injuries.<br>7. Written descriptions, body diagrams, photographs. | Chart whether the injuries are compatible with the patient's explanation.<br><br>***Assure the information is kept confidential.*** |
| **Do's** | ▪ Use the patient's own words in quotes whenever possible.<br>▪ Use written descriptions, freehand, body diagrams and/or photos.<br>– Be specific.<br>♦ Indicate the degrees of injuries.<br>♦ List indications of previous injury.<br>– Be neutral and non-judgmental.<br>– Outline the chronology of the problem.<br>– Include the patient's explanations.<br>– Record non-bodily evidence of torn clothing and broken jewelry.<br>▪ Refer the patient to Clinic Resource or community Domestic Violence advocate or State Domestic Violence Hotline Number 1-800-562-6025 V/TTY. | Note your concerns in chart notes.<br><br>***Be sure this information is kept confidential.***<br><br>If **SAFE** to DO SO, provide patient with Domestic Violence resource card.<br><br>Encourage patient to return to clinic if there are any problems in the future. |
| **Don'ts** | Do not discuss the patient's condition outside the clinic without the patient's written permission.<br>Do not confront or contact the suspected abuser.<br>Do not force the patient to have photos taken against her will. Photography is NOT acceptable in some cultures.<br>Do not use "Domestic Violence" as a diagnostic term. | Don't force the patient to divulge information. |

# Cultural Values: Through Language and Actions

As a health care provider, your goal is to facilitate patients to make safe decisions about their family members and their own well-being. When interacting with patients of diverse cultures regarding violence, it is important to be aware of the terminology used with them. The examples below illustrate ways in which you can share power with your patient to support them in making those decisions rather than directing them toward a course of action you select.

| Supportive | Directive |
|---|---|
| Do with | Do for |
| Work alongside | Lead |
| Assist | Control |
| Provide input | Advise |
| Facilitate | Determine |
| Provide additional resources | Impose additional requirements |
| Encourage | Mandate |
| Respect | Condescend |
| Display concern | Display paternalism |
| Demonstrate empathy | Demonstrate sympathy |

Courtesy of "Beyond the Mask of Denial: A Focus on Alcohol and Other Drug Concerns and Related to Prevention Issues that Face Asian and Pacific Islanders" Conference, Seattle, September 1993.

# STOP FEAR COALITION

Family Abuse Endangering Women & Children Abuse of all Kinds Rape & Sexual Assault

## Policy Statement on Couples Counseling and Anger Management in Domestic Violence Cases

*Judicial Sub-Committee, Stop F.E.A.R. Coalition of Rockland County*

As part of the community response to domestic violence[1] it is necessary for the justice system to look carefully at the programs to which defendants are referred. Anger management programs and couples counseling are sometimes requested or petitioned for in the court. While these methods may be effective for other types of problems, courts should not require couples counseling and/or anger management programs whenever domestic violence is present. These programs focus on therapeutic or treatment models, which disregard the dynamics of domestic violence and do not demand defendant accountability.

## Couples Counseling

Couples counseling depends on an open dialogue between partners. It cannot work without the presence of openness, flexibility, and the willingness to listen to one another. These traits are not possible when one person is emotionally or physically abusive to another.

People who are being either hit, intimidated, or controlled through threats or other coercive means by their partners are not free to engage in an open dialogue. If placed in couples counseling a person would be encouraged to speak openly about their partner's behavior and address problems in the relationship in the presence of an abusive partner. People who do so are often at risk of retaliatory tactics from the abuser, thereby jeopardizing their safety.

[1]For the purposes of this policy, domestic violence is defined as employing physical abuse or non-physical coercive or controlling tactics by one intimate partner against another

In couples counseling victims often take responsibility for instigating violence or participating in activities that supposedly precipitate the violence. Accountability is shifted from responsibility for the violence and the batterer is justified in the violence.

***The justice system should not order or encourage couples counseling in cases where there is an indication that a party is committing physical abuse or employing a non-physical coercive or controlling tactics.*** If the system were to do so, it could be placing victims at risk of experiencing additional abuse and/or control.

## Anger Management

Anger management programs as a tool for addressing domestic violence have not been demonstrated to be an effective way to stop the violence. Experts in the field of domestic violence have repeatedly stated that the most effective way to stop domestic violence is through a coordinated community policy of zero tolerance for domestic violence, including coercive and controlling tactics. Since the court is dealing with domestic violence as criminal behavior this policy must include treating it as such. Strong law enforcement measures such as mandatory arrests of aggressors and regular, demanding judicial monitoring of defendants are necessary aspects of an effective policy.

Anger management implies that the party is unable to control his anger and his behavior. In fact, perpetrators of domestic violence almost always control themselves very well. For example, they rarely strike out at their bosses or coworkers. They are often calm with the police and in court.

They know how to control themselves when they need to but do not feel the need to do so with their intimate partner. Although they often explain their violence

as a result of anger, domestic violence behaviors are almost always the result of a deliberate choice to exert power and control over a partner.

Anger management programs tend to focus on the person being unable to control certain violent or angry tendencies as a result of a triggering factor. Similar to couples counseling, this approach supports two dangerous myths. First, that the victim shares responsibility for the violence since they trigger it. Second, that the batterer is not responsible for the violence since he is not able to control it.

Anger management is a mental health approach to an issue of criminal behavior. It can give victims a false sense of safety because the victim may mistakenly believe that such a program can end the violence. The victim may be placed in grave danger and the likelihood of further violence could increase.

Anger management has not been shown to be efficacious in stopping domestic violence and should not be used by the judicial system as a substitute for either strong law enforcement or thorough judicial oversight of defendants. ***It is inappropriate for a court to order anger management for a defendant in a domestic violence case.*** To do so would be as inappropriate as ordering mental health therapy for a defendant who commits an assault upon a stranger.

## Judicial Response

When presiding over cases involving domestic violence judges are often asked by victims and defendants or their attorneys to either require or permit couples counseling or anger management as part of the resolution of the proceeding. When this type of request is made it is recommended that judges never require participation and respond by informing the parties of this policy statement.[2]

When victims of domestic violence suggest that the parties participate in couples counseling the court should not encourage this approach. The victim should be advised that although the court cannot prohibit couples counseling, the policy of the judicial system is that couples counseling is neither a safe nor appropriate approach to ending domestic violence.

Although courts should not attempt to prohibit individuals who wish to engage in anger management or couples counseling from doing so, it should not be part of a judicial response to domestic violence and consequently should not be encouraged by the court. Victims should be made aware that neither anger management nor couples counseling is a substitute for a strong law enforcement and judicial response to domestic violence. Victims should be cautioned that it may be dangerous to believe that anger management counseling will stop the violence.

[2]It is especially common for this request to be made to replace an order requiring attendance at a batterer's program (in Rockland it's the Volunteer Counseling Service (VCS) Domestic Violence Classes for Men). VCS Domestic Violence Classes for Men is a useful judicial monitoring tool, which provides a program of offender accountability. These classes are not part of any form of mental health treatment and mental health treatment should never be used as a substitute.

**Judicial Sub-Committee Members:** Hon William Warren, Rockland County Family Court Judge, Hon Margaret Garvey, Rockland County Family Court Judge, Hon Joseph Suarez, President Rockland County Magistrates Assn and Justice, Village of Chestnut Ridge, Hon Joel J. Flick, Justice, presiding over Domestic Violence Court, Town of Clarkstown, Hon Paul Phinney, Justice, Town of Orangetown, Ellen Woods, Senior Asst District Attorney, Kerri Fredheim, Senior Asst District Attorney, Theresa DiFalco, Asst District Attorney, Carolyn Fish, Exec Dir Rockland Family Shelter, Phyllis B. Frank, Dir, VCS Community Change Project, Catherine Fournier, Rockland Family Shelter, Jim McDowell, Criminal Justice Liaison, Community Change Project, Rachelle Kaufman, Senior Court Attorney, Rockland County Family Court

*For more information and references, contact Phyllis Franks, Director Volunteer Counseling Service of Rockland County Community Change Project, New York, New York.*
*Phone: 845-634-5729*

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on issues of domestic violence

# Why couples counseling may be INAPPROPRIATE for violent relationships

**Emily Chrysler, MSE, NCC and Aaron Milgrom, MA**

IN DAP'S TREATMENT PROGRAMS for abusers and abuse victims, we frequently encounter clients who have been through couples counseling before being referred to or seeking treatment for abuse. In these cases it is evident that the couples therapists either were not aware of the violence in these relationships, or they do not have an adequate understanding of the dynamics of abuse. Too often the result is that couples counseling not only fails to resolve the relationship problems, but may in fact contribute to increased violence.

The primary goal of couples counseling is an examination and adjustment of the balance of power in the relationship. This examination should take place in an environment with a level of safety that allows the partners to feel they can discuss differences openly, risk being vulnerable, and confront the typical fears about the future of the relationship such as depth of commitment and strength of common interests and goals. Violence and the fear of violence are not considered to be in the range of typical or "normal" relationship concerns. Violence and/or a history of violence in the relationship throws the power out of balance and prevents openness.

## How therapists can be drawn into the abusive relationship

It is not valid to assume that a "good" therapist can help couples who have experienced domestic violence. For these couples, equality and safety are displaced by the dynamics of unequal power and control. In this type of relationship, the abuser uses covert and/or overt violence to maintain control over the partner. The abused partner is intimidated and may fear being physically harmed. Typically, the abuse is a well-kept "family secret" and the observable evidence of an abusive relationship is often subtle and easily missed or dismissed.

Couples therapists are trained to help people move from behavior based on fears about the relationship toward resolving problems together by talking about them openly. Candor and cooperation are prerequisites to the success of the therapy. Because victims of domestic violence are likely to feel intimidated in the presence of their partners, they may appear to be neither candid nor cooperative during counseling sessions. Therapists may misconstrue this behavior and presume that this partner is unwilling to move past "normal" fears to work on the relationship.

This misjudging on the part of therapists can lead to severe repercussions for victims of abuse. Victims may be made to feel they are the cause of problems in the relationship because they are not willing to work in it. The abusers may, in turn, use this assessment of the therapist to justify further abuse and violence. Victims who implicate their abusers may be putting themselves in danger and suffer greater abuse for having shared what is often expected to remain secret.

## Misreading the dynamics of violent relationships

Therapists who are not specifically trained to work with couples who have experienced domestic abuse might either overlook or dismiss references indicating the abuse is occurring. Such indications could include:

- Signs of isolation on the part of the victim, such as confiding that "You are the only person I am telling this to."
- Showing intense fear in confrontational situations.
- Appearing to lack interest in talking about the problems of the relationship.

*Continued on page 2*

*Continued from page 1*

If the therapist is unaware of violence in a relationship, behavior might be misinterpreted. As in the observations often recorded by police called to the scene of a domestic assault, the therapist may see the victim as being out of control while the abuser appears extremely calm and rational in the counseling sessions. A victim's actions taken in self-defense might be mislabeled as abusive by both the abuser and the therapist.

If the couple shares information about a past occurrence of domestic violence, the therapist might be inclined to dismiss it as a bygone, failing to realize that even one occurrence of violence by one partner against another invariably changes the dynamics of equality in their relationship.

Abuse victims might choose not to disclose the violent nature of the relationship because:

- they fear that therapy will be denied
- they fear being punished by the abuser for speaking out
- they feel it is important not to appear vulnerable

## Ensuring the appropriateness of couples counseling

Every therapist working in family and couples counseling should be familiar with the dynamics of domestic violence. It is important to learn to recognize signs of a violent relationship in order to avoid putting the victim in a dangerous situation as a result of the therapy.

Therapists working with couples should implement a screening process for domestic violence. Because victims of abuse are unlikely to speak about their fears in their abusers' presence, screening should include an individual assessment of each partner.

The therapist should be aware that if a couple has experienced a domestic violence intervention in the past, or if the victim has been in a past abusive situation, they may be less likely to share information, already knowing the consequences of doing so. For instance, if a woman has previously reported a domestic assault or called police, she will be aware that her partner was most likely mandated to seek counseling for the abuse and possibly serve some jail time.

The therapist who recognizes that violence is occurring in a relationship must not make the mistake of believing it will stop if only the therapist can help the couple address the imbalance of power. This can be a trap. Working alone with the couple, the therapist is likely to reinforce the imbalance by unwittingly helping to blame the victim or helping to justify the abuser's behavior.

## Domestic violence program before couples counseling

Instead of attempting couples counseling with people who have a history of domestic violence, therapists should refer them to groups designed specifically for people who have been in abusive situations. A typical program will have separate classes for abusers and victims. In the abuser group the facilitator will recognize cognitive-behavioral therapy to help abusers:

- learn new methods and behaviors for dealing with their emotions
- learn to take responsibility for their actions
- Benefit from feedback from others who have similar beliefs and experiences
- create a self-control plan

The group for abuse victims will focus on helping them to:

- rebuild self-esteem
- learn that the abuse is not the fault of the victim
- create a protection plan for times of danger

Such a program allows the couple, if they choose to stay together, to redefine their relationships and their respective roles in it. It is this redefinition that brings people who have completed domestic violence programs back into couples therapy. At this point in the relationship, upon completion of the program, it is safer and more productive to administer couples therapy.

Studies show that often it is the victim of the domestic violence who initiates couples therapy after completion of the domestic violence program. In fact, such therapy may often be sought as a safe and structured way to end the relationship. It is important that therapists remain open to this outcome.

For partners who decide to stay together, couples counseling can help them rebuild the relationship.

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For more information on DAP: Deena Anders (danders@mndap.org) or call 612-874-7063 x222

## www.domesticabuseproject.org

- √ Review DAP's four main areas: Advocacy, Therapy, Training & Publications Research & Evaluation.
- √ Be introduced to DAP's philosophy and mission statement.
- √ Review DAP's services and get contact information
- √ Stay informed of upcoming trainings—and register online.
- √ Learn all about our great manuals.
- √ Order products online—manuals, T-shirts, sweatshirts.
- √ Download our complete Domestic Violence Awareness presentation complete with handouts—available for anyone to use in community education settings.
- √ This issue of the Training & Research Update will be on the website!

*We feel our new website is consistent with our goals of gaining an increased national and international presence and increasing awareness about domestic violence in our communities. We welcome your feedback about the website!*

# Domestic Violence and the Workplace

# Information and Resources

## What is Domestic Violence?

Domestic violence is a pattern of physical, sexual, and psychological behavior used to establish and maintain control in intimate relationships. It includes verbal and emotional abuse, threats of all types, slapping, punching, kicking, rape, and homicide – as well as many other forms of physical and psychological abuse. Violence almost always escalates in severity over time and may end in serious injury or death.

## Domestic Violence and the Workplace

The workplace has seen the implementation of many types of corporate programs: Chemical Dependency, Stress Reduction, Mental Health and Physical Fitness, to name a few. This is due to society's recognition that employees bring personal issues and problems to work and that these issues may result in expensive productivity declines and/or safety liabilities.

Domestic violence is just such a problem, costing U.S. businesses an estimated $3 to $5 billion annually due to stress, injuries, lost time and interruptions in employee work.

## Why Should Employers Care?

**Domestic violence compromises a healthy work environment in many ways:**

- Lost work time: in recent studies, 64% of battered women estimated they were an hour late for work five times per month because of abuse.
- Impaired work performance and greater safety risks due to stress and distractions.
- Increases employee turnover resulting from the need to change location to escape the abuser.
- Lost work time while in jail, at probation meetings, or court-appointed batterers treatment.
- Co-workers' concerns and fears for victim's situation.

## What Can Employers Do?

**There exists many opportunities for employers to help employees who are affected by domestic violence. A few ideas include the following:**

- Display posters that convey messages about the unacceptability of domestic violence.
- Allow employees to transfer sick or vacation time to each other to respond to domestic violence situations.
- Offer training to managers, personnel staff, and others, to identify signs of domestic violence and direct workers to employee assistance programs or community resources.
- Adopt formal/informal personnel policies that are responsive to the needs of domestic violence victims (leave for court appearances, transfers for safety, etc.).

*Washington State Hotline: 1-800-562-6025 V/TTY… call for further information*

## Warning Signs of Domestic Violence Often Emerge at the Workplace and May Include:

- Unexplained bruises or injuries
- Unexplained absences and/or tardiness
- Inability to concentrate and/or work efficiently
- Secrecy about phone calls and personal life
- Depression and anxiety
- Harassment by abusing partner

## Suggestions for Employees

- Keep phone on voice mail or answering machine to screen calls.
- Ask receptionist to screen calls and visitors and use a code word to signal trouble.
- Document harassing calls or visits by abuser.
- If protection order is violated, call police.
- Know escape routes from building area.
- Make a safety plan to protect yourself and your children, which include: asking for help from others, access to care keys and important papers, and phone number of local victim services and shelters.

## Your Rights Under the Law

Every person has the right to expect a life free from violence and the threat of violence. The following civil and criminal orders may be used to that end:

- Anti harassment Protection Order – Civil Court
- Domestic Violence Protection order – Civil Court, free
- Restraining Order – Civil Court (used only when filing for divorce, child custody, or paternity)
- No Contact Order (may be issued by court when an arrest has been made) – Criminal Court

## How to Help Someone Dealing with Domestic Violence

In knowing a co-worker, friend, or neighbor may be in a situation of domestic violence, most people want to help. At the same time people may have a certain amount of fear or concern on how to offer help. Fear or concern may stem from not knowing what resources to offer, how far into the situation one might be drawn, or concern regarding the safety of involvement.

**The following are some principles that guide most victim advocacy organizations in the roles of providing support and assistance and may also provide general guidance to giving support in any role or setting:**

- Information and resources are often the greatest needs a victim may have.
- Respond to a victim with compassion, and refrain from blame regardless of any opinions you have about the victim's personality, way of life, or choices made in their situation.
- Respect a victim's right to privacy and confidentiality, subject only to mandatory reporting laws regarding child abuse.
- Offer support in a manner that promotes the victim's ability to achieve and maintain a sense of safety, dignity, and personal power.
- Be aware of your own limits, abilities, and needs for personal and emotional safety as well.

# Washington State Domestic Violence & Pregnancy Facts

TO PROVIDE HEALTH CARE PROFESSIONALS (PHYSICIANS, MIDWIVES, NURSES, NUTRITIONISTS, SOCIAL WORKERS) WITH BASIC INFORMATION TO INCREASE THE SAFETY OF WOMEN EXPERIENCING DOMESTIC VIOLENCE DURING PREGNANCY.

## Provider Resources:

**Physicians Insurance: A Mutual Company**

Prenatal record forms are available on their website: **www.phyins.com**

**Washington State Coalition Against Domestic Violence**

General information, training, survivor video, and resources for health care providers.

Phone: 206-389-2515 x104, TTY 206-389-2900 or their website: **www.wscadv.org**

**DOH Perinatal Partnership Against Domestic Violence**

DV & Pregnancy: Guidelines for Screening & Referral—order form on website.

Website **http://www.doh.wa.gov/cfh/mch/perinatal_partners_against_dv.htm**

**DSHS Pocket Safety Cards**

Can be placed in provider office, lobby, or restrooms to provide brief safety planning.

Available in Chinese, Cambodian, English, Korean, Laotian, Russian, and Vietnamese.

Order on-line at no cost to you at: **www.prt.wa.gov**

...click on General Store; then register; shop by item type; click on cards & bookmarks; look for Publication No. 22-276, and order.

## Domestic Violence

A pattern of assaultive and coercive behaviors that include physical, sexual, psychological attacks, and economic coercion. The lack of well-established instruments for measuring psychological abuse, such as threats, denigrating remarks, or controlling economic or immigration status, limits most prevalence statistics to identifying physical assaults, although physical violence is just one aspect of domestic violence.

## Prevalence

Nationally, estimates for assaults to pregnant women range from 1 – 20% depending upon the study definition of assaults and the population studied (Saltzman, L.E. et. al 2003). Washington State tracks prevalence using PRAMS* Survey data. The percent of childbearing women who reported physical violence by a husband or partner around the time of pregnancy (12 months prior to pregnancy through 3 months postpartum) in 2000-2002 is approximately six percent. This translates to approximately 5,000 women per year around the time of pregnancy.

## What Health Care Providers Can Do

1. **ASK**—The most critical intervention is to ask, when patient is alone, questions about domestic violence. Screen all pregnant women every trimester and post partum using the Physicians Insurance Prenatal Record Questions.
2. **ASSURE SAFETY IF VIOLENCE IS DISCLOSED**—
   - Acknowledge the discloser
   - Be supportive
   - Explain confidentiality of records
   - Assure safety by asking:
     - Is your partner here?
     - Is it safe to leave the office?
     - Are you safe to go home?
   - If so, review the DSHS Pocket Safety Card (see reverse).
   - If not, provide a safe place for the patient to contact the State Domestic Violence Hotline (see reverse)
3. **REFER**—Refer women who report domestic violence to resources as part of a safety plan. (*see reverse for client referral resources*)

# Client Referral Resources—What to Expect

1. **Washington State Domestic Violence Hotline—1-800-562-6025** (V/TTY)
   - 24-Hour General information and referral to local domestic violence resources for victims, the general public, and professionals.
2. **Local Domestic Violence Agencies—www.wavawnet.org** provides a listing of local agencies and the services they provide. It is best to look up in advance and have materials located in your waiting area and in restrooms.
   - Advocacy services provide problem solving, safety planning, issue clarification, decision making skills, and ongoing support.
   - The advocate is required to keep information confidential (including if the referred person obtains services) for safety purposes.
3. **First Steps Programs—http://maa.dshs.wa.gov/** (Click on Eligibility for Medical Programs).
   - For low income women (185% of poverty level) the First Steps Program can be a good referral source for assuring linkage to services.

*PRAMS (Pregnancy Risk Assessment Monitoring System) is an ongoing population-based surveillance system sponsored by the Centers for Disease Control and Prevention, that survey new mothers who are representative of all registered births to Washington State residents. The Washington State Department of Health has been collecting PRAMS data since 1993. For more information, contact MCH Assessment at 360-236-2533 or visit the website at* **www.doh.wa.gov/cfh/prams/**.

# Why Ask? Why Refer?

**SAFETY**—Studies indicate:

- Women who experience physical abuse are at higher risk for miscarriages and low birth weight babies. (Campbell, et. al 1999; Cokkindes, et al, 1999; Murphy,et al 2001)
- A co-occurrence of domestic violence and child abuse ranges from 30% to 60% (Appel & Holden et al. 1998) This variation depends upon the study definitions of child abuse and domestic violence.

**SUPPORT**—Survivors of abuse indicate ("*The Voices of Survivors: DV Survivors Educate Physicians*", WSCDV Video) that:

- Asking about domestic violence in a confidential, private setting by a health care provider is viewed as helpful, caring intervention.
- Knowing a health care provider was open to talking about abuse helped survivors to eventually address the issue.

**BEST PRACTICE RECOMMENDATIONS**—In 2002, 60% of Pregnancy Risk Assessment Monitoring System respondents indicated that they had been asked by their prenatal care provider if someone had hurt them.

The following organizations support universal screening (see position papers at websites listed below:

- American College of Obstetricians and Gynecologists (ACOG) **www.acog.org**
- American Medical Association (AMA) **www.ama.org**
- American Academy of Family Physicians (AAFP) **www.aafp.org**
- American Nurses Association (ANA) **www.ana.org**
- National Association of Social Workers (NASW) **www.nasw.org**

# References—Suggested Reading

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Washington State Department of Health

# Appendix D

## Client And Community Education

AM I EXPERIENCING PARTNER VIOLENCE?

Look over the following questions. Think about how you are being treated and how you treat your partner. Remember, when one person scares, hurts or continually puts down the other person, it's partner violence.

**Does your partner....**

____Embarrass or make fun of you in front of your friends or family?
____ Put down your accomplishments or goals?
____ Make you feel like you are unable to make decisions?
____ Use intimidation or threats to gain compliance?
____ Tell you that you are nothing without them?
____ Treat you roughly - grab, push, pinch, shove or hit you?
____ Call you several times a night or show up to make sure you are where you said you would be?
____ Use drugs or alcohol as an excuse for saying hurtful things or abusing you?
____ Blame you for how they feel or act?
____ Pressure you sexually for things you aren't ready for?
____ Make you feel like there "is no way out" of the relationship?
____ Prevent you from doing things you want - like spending time with your friends or family?
____ Try to keep you from leaving after a fight or leave you somewhere after a fight to "teach you a lesson"?

**Do You...**

____ Sometimes feel scared of how your partner will act?
____ Constantly make excuses to other people for your partner's behavior?
____ Believe that you can help your partner change if only you changed something about yourself?
____ Try not to do anything that would cause conflict or make your partner angry?
____ Feel like no matter what you do, your partner is never happy with you?
____ Always do what your partner wants you to do instead of what you want?
____ Stay with your partner because you are afraid of what your partner would do if you broke up?

**If any of these are happening in your relationship, talk to someone. Without some help, the violence will continue.**

## RESOURCE LIST

You can contact the following numbers for help:

### 24-HOUR EMERGENCY/ POLICE

Dial 911

### *Domestic Violence REFERRAL*

*WA State Domestic Violence (24-hour) Hotline 1-800-562-6025*

### SHELTERS *(interpreters available)*

New Beginnings (24-hour hotline) Interpreters available
206-522-9472

Eastside Domestic Violence (24-hour hotline)
425-746-1940

Domestic Violence Abuse Women's Network (24-hour hotline)
206-656-7867

### AGENCIES WITH BILINGUAL STAFF

Asian Pacific Islander Women and Family Safety Center
(Languages: Tagalog, Korean, Samoan)

206-467-9976
Refugee Women's Alliance
(Languages: Cantonese, Mandarin, Cambodian, Ukrainian, Russian, Amharic, Tigrinya, Lao, Thai, Somali, Tagalog, Vietnamese)
206-721-0243

Chinese Information Service Center
(Languages: Mandarin, Cantonese)
206-624-4062

Korean Community Counseling Center (Language: Korean) 206-784-5691


INTERNATIONAL COMMUNITY
HEALTH SERVICES
720 - 8th Ave South, Suite 100
Seattle, WA 98104

**Why are you asking me about safety?**

Violence between partners or by family members does happen before, during and after pregnancy. ICHS staff can help. We can listen, give you information and link you to people who can help you in a private and safe way.

Talking about the violence you experience can be a first step to making things better.

What kind of questions does ICHS ask?

- Some questions ICHS providers might ask include:
- "Are you safe?"
- "How is your relationship with your partner or family?"
- "Have you been hit, kicked or slapped?"
- "Have you had unwanted sexual contact with a partner?"

We ask these questions to find out if your partner or a relative is using physical, sexual or verbal behavior (threats of economic loss or your immigration/ refugee status) against you. We want to help you and your baby be safe.

What are examples of violent behaviors?

- Pushing, shoving, slapping, hitting, punching, kicking, holding, tying you down, throwing things at you or
- destroying property or hurting family members.
- Any form of unwanted and forced sex or sexual contact, including:
  - Trying to or making you perform sexual acts against your will.
  - Making sexual contact when you are not fully conscious, or are not asked, or you are afraid to say no.
  - Physically hurting you during sex or attacking your body, with or without the use of an object or weapon.
- Using of a weapon to control you.
- Keeping track of where you are.
- Making decisions for you.
- Controlling the money.
- Keeping you from your family.

Why do you ask questions about partner/family violence so often during and after my pregnancy?

Women who experienced violence in relationships told us that asking these questions often would help them feel more comfortable in talking with someone about the violence.

Partner/family violence is difficult to talk about. It might take several times of being asked before a woman can confide in someone about her violence situation.

Is it safe to tell ICHS providers about my partner/family violence situation?

We will talk with you in a private room without the presence of family or friends.

Your responses will be kept confidential and will not be revealed to others without your permission.

Professional interpreters are available to interpret and will also keep to the confidentiality policy of ICHS clinic.

**What if I am not in a violent relationship?**

We want you to know that if you ever experience violence, you can always talk to one of our providers. We will be ready and willing to help.

If you are experiencing partner/family violence and not ready to talk, we understand. When you feel ready, let our providers know your concerns and we will try our best to help.

## What if I tell you about possible/actual abuse occurring in my home?

ICHS providers will listen and ask you questions to better assist you.

With your permission, the provider will refer you to a trained clinic staff or to a community person who is trained to talk with you about partner/family violence issues.

Whether you choose to leave your home or stay, these trained specialists can work with you on a plan to keep you safe. If you choose to leave your home, they can help you find a place to stay. If needed, they may also help with legal issues or find legal assistance as well as connect you to other information at your request.

This material was adapted from materials provided by SafePlace Shelter/Advocacy, Olympia, Washington.

If someone you love hurts you…

# *You Can Get Help!*

## Does Your Partner:

**Embarrass you with bad names and putdowns?**

**Look at you or act in ways that scare you?**

**Control what you do, who you see or talk to, or where you go?**

**Stop you from seeing or talking to friends or family?**

**Take your money, make you ask for money, or refuse to give you money?**

**Make all the decisions?**

**Tell you that you're a bad parent or threaten to take away or hurt your children?**

**Act like abuse is no big deal, it's your fault, or even deny doing it?**

**Destroy your property or threaten to kill your pets?**

**Intimidate you with guns, knives, or other weapons?**

**Shove you, slap you, or hit you?**

**Threaten to commit suicide?**

**Threaten to kill you?**

**THIS CARD CAN HELP KEEP YOU SAFE**

Place Safety Cards Here.

# Fact or Myth Game

| | | | | | |
|---|---|---|---|---|---|
| **1**<br>**FACT** or ***MYTH***<br>1 in 4 pregnant women have a history of partner violence. | **2**<br>**FACT** or ***MYTH***<br>An estimated 45% of abused women are forced into sex by their partners. | **3**<br>**FACT** or ***MYTH***<br>It is best to keep the family together. | **4**<br>**FACT** or ***MYTH***<br>Women experiencing Domestic Violence are at increased risk for pelvic inflammatory disease, sexually transmitted diseases, and other health problems relating to genital and urinary organs. | **5**<br>**FACT** or ***MYTH***<br>Domestic Violence occurs mainly in low-income populations. | **6**<br>**FACT** or ***MYTH***<br>3.2% of Asian and Pacific Islander women who delivered babies in Washington State (1996 – 1999) reported physical abuse during pregnancy. |
| **7**<br>**FACT** or ***MYTH***<br>Women are just as violent and abusive as men. | **8**<br>**FACT** or ***MYTH***<br>Somatic complaints associated with Domestic Violence include sleep disorders, gastrointestinal problems, muscle tension, headaches, palpitations, hyperventilation, or choking sensations. | **9**<br>**FACT** or ***MYTH***<br>Batterers are violent in all of their relationships. | **10**<br>**FACT** or ***MYTH***<br>Battered women must enjoy the abuse; otherwise they would leave. | **11**<br>**FACT** or ***MYTH***<br>Psychological and emotional problems associated with abuse include: depression, anxiety and fear, lowered self-esteem, rage, dissociation, Post Traumatic Stress Disorder, and Multiple Personality Disorder. | **12**<br>**FACT** or ***MYTH***<br>Alcohol and drug use cause domestic violence. |

Asian Pacific Islander Coalition Against Domestic Violence (APICADV)

# Instructions for Fact or Myth Game

## OBJECT OF THE GAME

1. To visit all 12 exhibitors.

2. To see if you can guess which of the 12 statements on your Fact or Myth Game Card is a "fact" or a "myth".

3. To get stickers in all 12 spaces.

## WHO IS ELIGIBLE TO PLAY

Everyone that gets a Fact or Myth Game Card from the ICHS Table.

**HOW DOES IT WORK?**

1. All exhibitors have been assigned a number from 1 to 12. You will see their number displayed in front of their booth.

2. Take your Fact or Myth Game Card (which has 12 "Fact or Myth" statements) to any exhibitor booth. Look for the exhibitor's number. Find the statement on your Fact or Myth Game Card that has the same number and tell the staff person if you think the statement is a Fact or Myth.

3. The staff person will tell you the correct answer. Either way, you will get a sticker.

4. Keep going to each exhibitor table until all 12 game squares have stickers.

5. Take your completed Fact or Myth Game Card to the ICHS Table to collect your prize.

You may keep your Fact or Myth Game Card for future reference.

# Answer Key – Fact or Myth

**#1. FACT:** 1 in 4 pregnant women have a history of partner violence.

*Resource: Journal of the American Medical Association, 1992*

**#2. FACT:** 40 to 45% of abused women are forced into sex by their male partners.

*Resource: Campbell JC and Lewandowski LA. Mental and Physical Health Effects of Intimate Partner Violence on Women and Children. Psychiatrics Clinics of North America. 1997; 20(2): 353-374.*

**#3. MYTH:** It is best to keep the family together.

Separation might be necessary for the woman and the children to be safe. Keeping the family together or encouraging reconciliation may increase the risk of harm or death.

*Resource: Clark County Prosecuting Attorney's Office.*

**#4. FACT:** Women experiencing domestic violence are at increased risk for pelvic inflammatory disease, sexually transmitted diseases, and other health problems relating to genital and urinary organs.

*Resource: Campbell JC and Lewandowski LA. Mental and Physical Health Effects of Intimate Partner Violence on Women and Children. Psychiatrics Clinics of North America. 1997; 20(2): 353-374.*

**#5. MYTH:** Domestic Violence occurs mostly within low-income populations.

Research indicates that there are no socioeconomic barriers to domestic violence. Women of all cultures, races, occupations, income levels, and ages are battered – by husbands, boyfriends, lovers, and partners. Low-income people are more likely to use public hospitals and are more likely to come to the attention of official agencies. Middle-class women are less likely to seek assistance because they fear personal embarrassment and the possible damage to their husband's career if the violence was disclosed.

*Resource: National Committee on Violence, 1989; Straus, Gelles, & Steinmetz, 1980; Surgeon General Antonia Novello.*

**#6. FACT:** 3.2% of Asian and Pacific Islander women who delivered babies in Washington State (1996 – 1999) reported physical abuse during pregnancy.

A Centers for Disease Control Survey of random sample of women who delivered babies in Washington State. The survey asks, "Have you experienced physical abuse during your pregnancy by husband/partner/family/friend?" The majority of API women reported that husband/partners were the most frequent. This data is under-reported because the survey was not translated into various languages or completed by personal interview. More detail will be required to further explore this issue.

*Resource: Washington State Pregnancy Risk Assessment Monitoring System.*

**#7. MYTH:** Women are just as violent and abusive as men.

Wife abuse is one of the main reasons for women to be seen in hospital emergency rooms. When women hit or scratch, it is often in self-defense. In over 95% of domestic assaults, the man is the perpetrator.

*Resource: Sylvia's Place, Allegan County Domestic Violence Shelter; Jewish Action: The Magazine of the Orthodox Union. Spring 4748/1998. Vol. 58 No. 3*

**#8. FACT:** Somatic complaints associated with Domestic Violence include sleep disorders, gastrointestinal problems, muscle tension, headaches, palpitations, hyperventilation, or choking sensations.

*Resource: Bohn DK and Holz, KA. Sequel of Abuse: Health Effects of Childhood Sexual Abuse, Domestic Battering, and Rape. Journal of Nurse-Midwifery. 1996; 41(6): 442-456. Naumann P, Langford D, Campbell J, and Glass N. Women Battering in Primary Care Practice. Fam Prac. 1999; 16(4): 343-352.*

**#9. MYTH:** Batterers are violent in all of their relationships.

Abusers often appear to be charming and helpful. Abuse is about control, not anger. Those who claim their wife made them hit them because she "pushed his buttons" wouldn't dream of acting that way to a boss or policeman, no matter how angry he was. Most batterers choose to be violent only with their partner. There are relatively few consequences for using abuse and violence in an intimate relationship, while the use of violence outside the home is more likely to be penalized.

*Resource: Jewish Action – The Magazine of the Orthodox Union. Spring 5758/1998. Vol. 58 No. 3; Bridgeway Counseling Services, Inc.*

**#10. MYTH:** Battered women must enjoy the abuse; otherwise they would leave.

Texas Council on Family Violence indicated that most 70% of abused women eventually do leave. Leaving is a process, not an event. A woman must make several attempts to leave her abuser before in fact is completely successful. Abused women are usually constrained from leaving home by a number of factors including:

1. Fear of Reprisals – Women who leave are 75% more likely to be killed than those who stay.

2. Social Isolation – Survivors are isolated from family and friends due to shame or lack of understanding displayed by people; many abusers deliberately isolate women from sources of support.

3. Economic Dependence – Nationally, 50% of all homeless women and children are on the streets because of violence in the home. *(Senator Joseph Biden, US Senate Committee on the Judiciary, Violence Against Women: Victims of the System, 1991).*

4. Lack of Knowledge and Access to Help – Survivors may lack knowledge of Domestic Violence services. Some may experience language difficulties, inappropriate responses from service providers or living in isolated areas.

5. Emotional Dependence – False hope that abuser may change and the violence will stop.

6. Staying Because of the Children – 49% of women believed that keeping marriage together because of the children was a reason preventing them from leaving. (1982 Victorian Domestic Violence Phone-In Survey).

7. Shame – After years of abuse, survivors may lose self-confidence and doubt in their ability to cope on their own.

*Resource: "Shattered Lives" fr. Killeen Daily Herald; Health Department. Western Australia; WISE-Women's Issues & Social Empowerment; SafetyNet; Sound Vision Foundation, Inc.; Sanford Police Dept.; Oakland County Coordinating Council against Domestic Violence.*

**#11. FACT:** Several studies indicate that psychological and emotional problems such as depression, anxiety and fear, lowered self-esteem, rage, dissociation, Post Traumatic Stress Disorder, and Multiple Personality Disorder are associated with abuse.

*Resource: Cohn, F; Salmon, M& Stobo, J (eds) Confronting Chronic Neglect: The Education & Training of Health Professionals on Family Violence, Institute of Medicine, National Academy Press 2001, Chapter 1 page 30.*

**#12. MYTH:** Alcohol and drug use cause domestic violence.

Many batterers never drink and many people who abuse alcohol never batter. Only 1 in 3 of batterers batter when they drink. Alcohol use, drug use, and stress do not cause domestic violence; they may go along with domestic violence, but they do not cause the violence. Abusers often say they use these excuses for their violence. *(Michigan Judicial Institute, Domestic Violence Benchbook, 1998. p 1. 6-1.7).* Because substance abuse does not cause domestic violence, requiring the batterers to only attend substance abuse treatment programs will not effectively end the violence. Many people who are under stress do not assault their partners. Assailants who are stressed at work do not attack their co-workers or bosses. The majority of violent men are not mentally ill nor are they psychopaths. Most offenders present themselves as ordinary, respectable men who are very much in control. They are represented in all occupations and social classes, and the violence usually manifests itself only within their relationships with their intimate partner and children. Domestic violence is not an anger management issue. People who are abusive are usually not violent towards anyone other than their wives/partners and/or their children. They can control themselves sufficiently to pick a safe target. Offenders are also able to control the way in which they abuse, including limiting the physical assault to certain, often hidden, parts of the body and by limiting the amount of damage inflicted.

*Resource: Health Department of Western Australia; Sylvia's Place, Allegany County Domestic Violence Shelter; Boulder County Safehouse; Bridgeway Counseling Services, Inc.; Oakland County Coordinating Council Against Domestic Violence.*

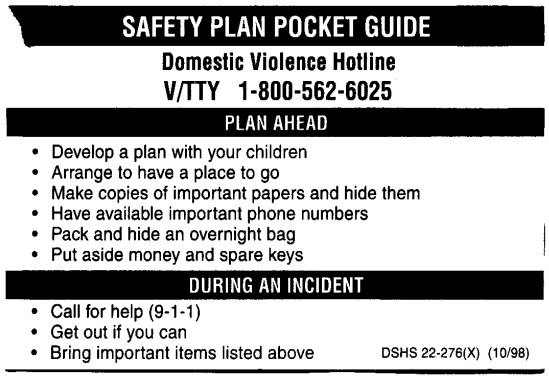
# Process for Ordering DSHS Safety Cards

You can order the DSHS Safety Cards for your office or clinic by following the information below. If you have difficulty with the process, please feel free to contact Judith at (253) 395-6739 to problem solve.

For Safety Cards in Chinese, Cambodian, English, Korean, Laotian, Russian, and Vietnamese, use the following process on-line:

1. Go to the Department of Printing website: www.prt.wa.gov/
2. Register by putting in your email address and a password.
3. Once registered, go to **General Store**.
4. Select "Shop by Agency".
5. Select DSHS.
6. Select Economic Services Administration.
7. Select General Economic Services.
8. Look for cards under 22-276 for the languages you need.
9. Follow instructions for ordering cards. Please note that although the cards come in a unit of 100 you must order the exact number of cards you want.

The cards are very simple and basic. In handing out the cards, please share with patients that they need to talk with an advocate or social work staff person to discuss details.



**SAFETY PLAN POCKET GUIDE**

**Domestic Violence Hotline**
**V/TTY 1-800-562-6025**

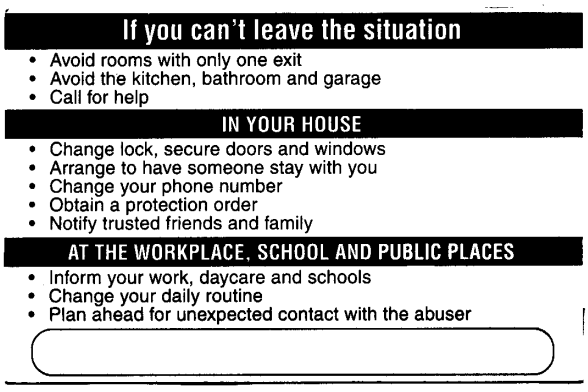
**PLAN AHEAD**

- Develop a plan with your children
- Arrange to have a place to go
- Make copies of important papers and hide them
- Have available important phone numbers
- Pack and hide an overnight bag
- Put aside money and spare keys

**DURING AN INCIDENT**

- Call for help (9-1-1)
- Get out if you can
- Bring important items listed above

DSHS 22-276(X) (10/98)



**If you can't leave the situation**

- Avoid rooms with only one exit
- Avoid the kitchen, bathroom and garage
- Call for help

**IN YOUR HOUSE**

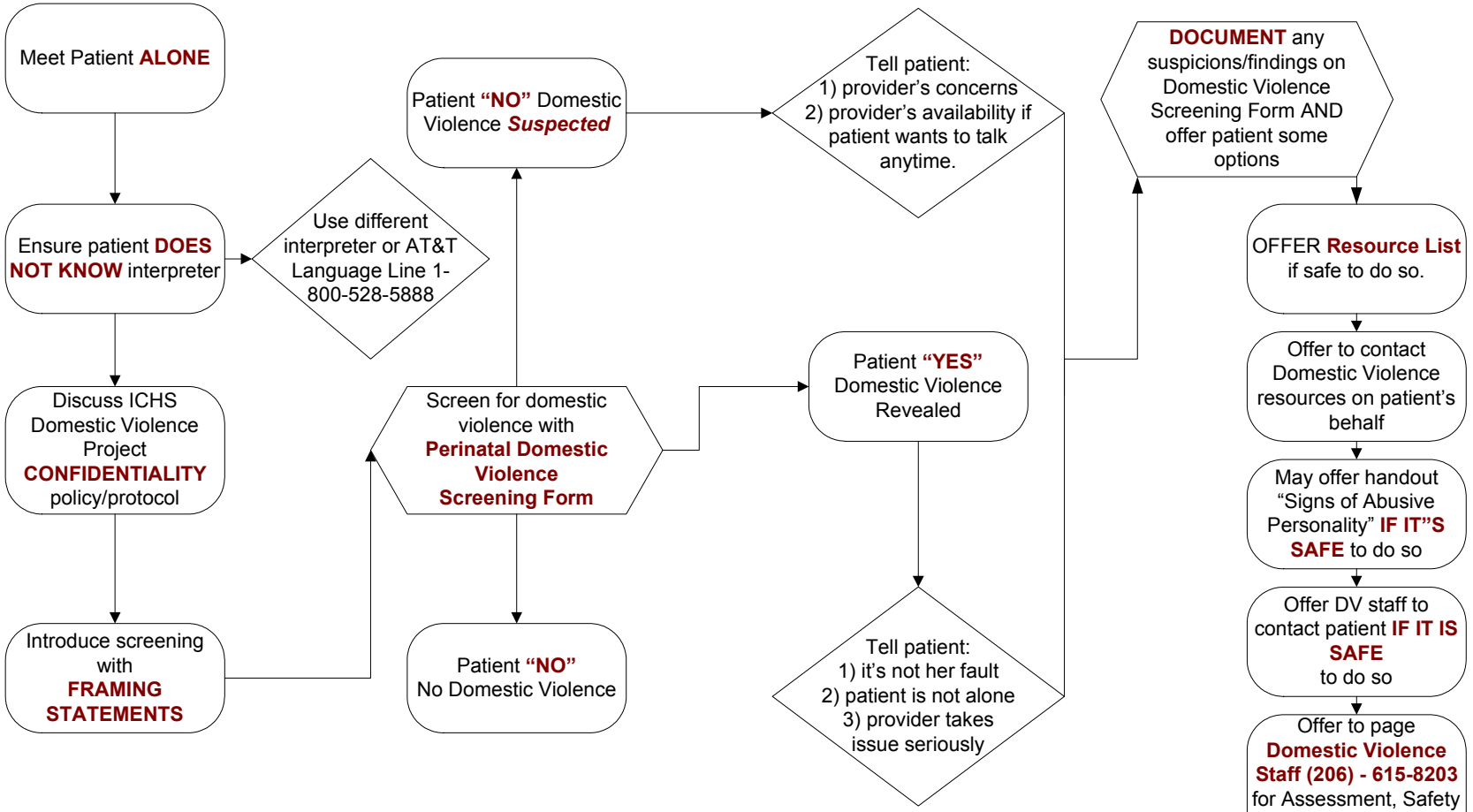
- Change lock, secure doors and windows
- Arrange to have someone stay with you
- Change your phone number
- Obtain a protection order
- Notify trusted friends and family

**AT THE WORKPLACE, SCHOOL AND PUBLIC PLACES**

- Inform your work, daycare and schools
- Change your daily routine
- Plan ahead for unexpected contact with the abuser

# Appendix E

## Protocols and Tools




If in-house Domestic Violence Staff is unavailable, provider/patient may contact the following 24-hour Domestic Violence Hotline numbers:
Chaya (serves S. Asian women in Seattle) 877-922-4242 or 206-325-7867
Domestic Abuse Women's Network (south Seattle) 206-656-7867
Eastside Domestic Violence (east Seattle) 425-746-1940
New Beginnings for Battered Women and their Children (north Seattle) 206-522-9472
Washington State Domestic Violence Hotline 1-800-562-6025 (for clients only)

International Community Health Services

# Perinatal Domestic Violence Screening Protocol

This Domestic Violence Protocol is developed by the International Community Health Services in collaboration with the Asian Pacific Islander Women and Children Safety Center with materials adapted from Domestic Violence protocols and/or screening tools of the following agencies: Moses Lake Community Health Care Center (Moses Lake, WA), Perinatal Partnership Against Domestic Violence (Seattle, WA), Women in Safe Homes (Ketchikan, Alaska), YVFWC Community Health Services Department (Seattle, WA), Family Violence Prevention Fund (San Francisco, CA), Pennsylvania Coalition Against Domestic Violence, Na Wahine Team (Honolulu, HI), New York Department of Health (New York, NY), New Beginnings (Seattle, WA), Providence Health System (Seattle, WA), AWAKE (Boston, MA.), Beth Israel Deaconess Medical Center (Boston, MA), RESPOND Inc. (Somerville, MA).

## Definition of Domestic Violence

Domestic violence is a pattern of assaultive and coercive behaviors which includes physical, sexual, psychological attacks, as well as economic coercion and use of immigrant/refugee status, that adults or adolescents use against their intimate partners to control and have power over them. Many acts of domestic violence are not criminal; however, the coercive effects on the abusive victims are all the same. (For additional information, see **Signs to Look for in an Abusive Personality** handout).

## Domestic Violence Protocol Goals and Objectives

The International Community Health Services' (ICHS) goal is to ensure the health and well being of all ICHS patients. The goals for ICHS Domestic Violence protocol are to identify perinatal patients experiencing Domestic Violence, prevent further injury, and facilitate safety for victims and their family members.

Specific ICHS Domestic Violence protocol objectives include:

- Providing ICHS providers with the definition of domestic violence.
- Encouraging ICHS providers to communicate concern for the victim's safety.
- Screening perinatal patients every trimester to identify domestic violence.
- Safeguarding the victim against further victimization through documentation of injuries and how they were sustained.
- Diagnosing, treating, or referring patients with domestic violence related injuries, illnesses, and other indicators caused by ongoing or past victimization to local support services.
- Referring victims to in-house Domestic Violence Coordinator or a community Domestic Violence Advocate for Domestic Violence Risk Assessment and Safety Planning when appropriate.

- Referring victim and their family to in-house Domestic Violence Coordinator or a community Domestic Violence Advocate for providing further resources and referrals to domestic violence advocacy, law enforcement, and/or court system.

## Confidentiality

ICHS perinatal patients and survivors identified CONFIDENTIALITY AS THE MAIN CONCERN in discussing and disclosing domestic violence to providers.

Let the patient know that any collected information regarding domestic violence will be **PROTECTED** and **SAFE**.

Below are procedures regarding safety and confidentiality for ICHS patients when providers perform routine domestic violence screening.

I In Person or Clinic Visits

A. Always meet with the patient ALONE for Domestic Violence screening.

B. If the patient needs an interpreter/family health worker (FHW)…

1. Make sure that the patient "approves" of the interpreter/FHW and feels safe in having him/her interpret. It is best that the interpreter/FHW does not know the patient outside of ICHS. You could verify this by speaking with the interpreter/FHW in advance.

a. If the interpreter is not an ICHS staff, make sure that the approved interpreter agrees with ICHS confidentiality policy.

2. If the patient does not feel comfortable with the provided interpreter/FHW and no other interpreter/FHW is available, offer the ATT telephonic interpreter line as an option.

C. DO NOT allow anyone who knows the patient to be present while the patient meets with the provider.

1. No partner.

2. No in-laws, relatives, or children.

3. No same-gender friends.

4. No interpreter who has personal connection.

D. If the partner is hostile or insists on staying with the patient.

1. Send the partner out to the waiting area.

2. Tell the person that the provider needs to do the physical exam alone.

3. Have a clinic plan for partner/relatives who become hostile. (Refer to ICHS Safety and Security Policy.)

E. DO NOT confront or contact the suspected abuser.

F. NEVER discuss the patient's condition outside the ICHS clinic without the patient's written permission.

G. Explain to the patient the ICHS procedure to keep information safe.

1. Let the patient know that all information shared will be confidential in the patient's chart; and within the confines of the law, will NOT be revealed to anyone else without her consent.

2. EXCEPTION: According to Washington State Laws, all cases of child abuse and neglected adults must be reported.

a. Let the patient know that it is the law that providers are mandated to report any disclosure of child or elderly abuse and neglect.

b. If the patient has revealed about cases of child/elderly abuse and neglect, let her know that it would be best if she makes the call with you.

c. For reporting, contact the Department of Social and Health Services toll-free number: 1-866-END-HARM. When you call, you will speak with a real person, who will connect you to the direct number to make your report. The answering service operates seven days per week, 24-hours per day.

II. Confidentiality of Records

A. Refer to **ICHS Confidentiality Policy** for further information on…

1. Patient's right to access medical records.

2. Protocol for medical information confidentiality

3. Procedure for handling medical record request

4. Faxing medical records

5. Documentation of health records

6. General Policy for destruction of confidential records

B. All charts are kept in the locked and secured ICHS Medical Records Room.

# Screening

Below are screening procedures for domestic violence. (In order to provide optimal screenings, all providers who screen will be trained on screening tools, procedures, and safeguards established for domestic violence screening at ICHS, and will be provided with on-going assistance.)

I. Screening Introduction

A. Introduce the screening with framing statements (See Appendix D: Provider Guide to Domestic Violence Screening Questions for Possible Victims of Domestic Violence handout) to normalize the screening process and provide the rationale for screening. Providers may do so by informing the patient that Domestic Violence screening is a matter of ICHS clinic policy for pregnant and post-partum patients.

Example: *"Domestic violence is a common problem in women's lives, we now ask all perinatal patients about domestic violence.*

B. Ensure the patient's comfort by…

1. Paraphrasing screening questions when appropriate.

a. Take into account individual patient's comfort. This may include the patient's personal belief about domestic violence, gender roles, privacy, cultural communication style, and cultural perspective.

b. For example, asking directly about domestic violence in some cultures might be regarded as "rude" or "intrusive." In which case, using indirect questions before asking specific, direct questions might be a preferable approach. (See Appendix D: Provider Guide to Domestic Violence Screening Questions.)

2. Use compassionate language and gestures to let the patient know that you take the issue seriously.

II. When to ask about Domestic Violence

Data collected have shown that ICHS providers have selected to screen for domestic violence at least once every trimester in accordance with recommendations from the American College of Obstetricians and Gynecologists (ACOG).

Ask at specific intervals:

A. First Trimester

1. The First Trimester screening includes Domestic Violence screening at OB Initial visit and 1 month return visit of patients of to 3-months pregnant.

2. The OB Coordinator is responsible for screening during this time. The Domestic Violence screening questions designated for Trimester One can be found under the "Present Pregnancy History" section, bottom left corner of page 1 of the Prenatal Record **(**See Appendix E).

B. Second Trimester

1. Second Trimester screening includes Domestic Violence screening patients 4 to 6 months pregnant at monthly visits.

2. The OB/GYN is responsible for screening during this time. The Domestic Violence screening questions designated for Trimester Two can be found under the "Anticipatory Guidance, Second Trimester" section, mid-right, page 2 of the Prenatal Record form. (See Appendix E).

C. Third Trimester

1. Third Trimester screening includes monthly visits of patients in the 7th month and bi-monthly visits of patients 8 to 9 months pregnant.

2. The OB Physician is responsible for screening during this time. The Domestic Violence screening questions designated for Trimester Two can be found under the "Anticipatory Guidance, Third Trimester" section, mid-right, page 2 of the Prenatal Record form. (See Appendix E).

III. Completing Perinatal Domestic Violence Screening Questions

A. All charting of Domestic Violence screening will be recorded on the Prenatal Record form at the designated location for each trimester. (See Prenatal Record).

B. For Trimester One, the OB Coordinator is responsible for completing the below questions on page one of the Prenatal Record.

1. Note that a sample framing statement has been included to introduce the screening questions.

2. Simply mark with an "X" for a check mark next to the patient's response.

---

**Domestic violence is common in women's lives. We ask all perinatal patients about Domestic Violence**.

Have you ever…

Been hit/slapped/kicked/pushed/physically hurt? _____Yes _____ No

Experienced uncomfortable touching/forced sexual contact? _____Yes _____ No

---

3. For trimester two and three, the OB Physician is responsible for completing the below on page 2 of the Prenatal Record.

    a) No framing statements are provided, and the questions are not scripted out, however, the provider should feel free to use the same statements and questions in trimester one to screen for Domestic Violence in trimester two and three.

    b) Simply mark with an "X" for a check mark next to the patient's response.

    PHYSICAL ABUSE _____ Yes _____ No

    SEXUAL ABUSE _____ Yes _____ No

IV. If the patient refuses to answer any or all of the provided screening questions:

A. Honor her decision.

B. Note the patient's action next to the Domestic Violence question.

C. Provide the patient with a **Domestic Violence Resource List** (see Appendix E: ICHS Safety Cards) and let her know that if she or someone close to her is ever in need of domestic violence assistance to contact the listed agencies.

Example: *"Domestic violence is a very common problem. Here is a resource list if you or someone you care about are ever in need of any family-related assistance."*

D. If the patient says that Domestic Violence is not occurring but the provider is concerned about abuse:

1. Note provider's concern next to the Domestic Violence question on **Prenatal History** form.

2. Use thoughtful questions, supportive responses, and engaged body language to build trust and elicit important information. Let the patient know the provider's concerns and ensure the patient understands that the provider will do the utmost to protect her safety and well-being.

3. IF IT IS SAFE to do so, provide the patient with a **Domestic Violence Resource List** (see Appendix D) and let her know that if she or someone close to her is ever in need of domestic violence assistance to contact the listed agencies.

Example: *"Domestic violence is a very common problem. Here is a resource list if you or someone you care about are ever in need of any family-related assistance."*

4. Encourage the patient to return to the clinic if there are any problems in the future, and/or to contact any of the resources that have been provided.

5. If Domestic Violence is suspected, refer the patient to the ICHS Coordinator or a community Domestic Violence Advocate (see Appendix E: ICHS Safety Cards) for further Domestic Violence Assessment and Safety Planning.

    a. ALWAYS ASK THE PATIENT FOR PERMISSION BEFORE sharing any of the patient's disclosed and personal information to referred resources.

    b. For emergency after hours and weekends, call 911 or the Washington State Domestic Violence 24-Hour Hotline at 1-800-562-6025. Let the operator know the language that the patient speaks.

    c. For non-emergency referrals, provide the patient with the Domestic Violence Advocate/Coordinator's contact number and if permitted, leave a message for the Domestic Violence Advocate/Coordinator to contact the provider/patient during the week.

VI. If the patient discloses domestic violence:

A. If the patient answers "Yes" when screening for Domestic Violence or shares any Domestic Violence experience, let the patient know that the violence and/or coercive behaviors are not her fault, and that the provider is glad the patient confided.

Let the patient know…

1. That the provider takes the issue seriously.

2. The patient is not alone.

3. The provider is comfortable hearing about the abuse, and help is available.

B. Ask the patient what she wants to do.

Recommend the patient work with the ICHS Domestic Violence Coordinator or a community Domestic Violence Advocate (See Appendix E: ICHS Safety Card).

1. ALWAYS ASK FOR PERMISSION before disclosing patient's name and phone number to contacted Advocate(s).

2. The Advocate will further work with the patient on risk assessment and safety planning.

3. For emergency after hours and weekends, call 911 or the Washington State Domestic Violence 24-Hour Hotline at 1-800-562-6025. Let the operator know the language that the patient speaks.

4. For non-emergency referrals, provide the patient with the Domestic Violence Advocate/Coordinator's contact number and if permitted, leave a message for the Domestic Violence Advocate/Coordinator to contact the provider/patient during the week.

## Documentation

Contact Domestic Violence Coordinator for documentation procedures of domestic violence victims sustaining suspicious wounds or injuries (see Appendix D, Provider Guide: Documenting Suspected/Disclosed Domestic Violence).

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## International Community Health Services
## PERINATAL Domestic Violence SCREENING

Patient Name:_____ Chart Number:_____

Baby Due Date:_____ Baby's Date of Birth:_____

Termination/Miscarriage: Yes ☐ No ☐ Date of Termination/Miscarriage:_____

**Perform routine screening of all perinatal patients. Talk with patients alone. Use framing statements. Paraphrase questions as relevant to patient's comfort and cultural background.**

| ROUTINE VISITS | SCREENING QUESTIONS<br>Choose one:<br>Y = "Yes" patient response/Domestic Violence revealed<br>N = "No" patient response/No Domestic Violence<br>S = "No" patient response/Domestic Violence suspected by provider<br>R = Patient refused screening<br>In the past year/since your last visit… | | | REFERRALS<br>Choose all that apply:<br>1 = ICHS Domestic Violence Staff<br>2 = ICHS Psychologist<br>3 = Community-based Domestic Violence Advocate<br>4 = Women's shelter<br>5 = Hotline<br>6 = Non-referral<br>**7 = Domestic Violence Resource List Provided**<br>8 = Other Referrals |
|---|---|---|---|---|
| | …Has anyone repeatedly said things that caused you shame or put you down? | …Has anyone hurt, harmed, or threatened you? | …Has anyone made you feel uncomfortable by touching you or making you have sex when you don't want to? | |
| PREGNANCY DETECTION<br>Screened by: _____Physician _____Nurse _____Other _____WIC _____Dental<br>_____ Initials _____ Date | | | | |
| Screened by: _____Physician _____Nurse _____Other _____WIC _____Dental<br>_____ Initials _____ Date | | | | |
| 1st TRIMESTER<br>Screened by: _____Physician _____Nurse _____Other _____WIC _____Dental<br>_____ Initials _____ Date | | | | |
| Screened by: _____Physician _____Nurse _____Other _____WIC _____Dental<br>_____ Initials _____ Date | | | | |
| 2ND TRIMESTER<br>Screened by: _____Physician _____Nurse _____Other _____WIC _____Dental<br>_____ Initials _____ Date | | | | |
| Screened by: _____Physician _____Nurse _____Other _____WIC _____Dental<br>_____ Initials _____ Date | | | | |
| 3RD TRIMESTER<br>Screened by: _____Physician _____Nurse _____Other _____WIC _____Dental<br>_____ Initials _____ Date | | | | |
| Screened by: _____Physician _____Nurse _____Other _____WIC _____Dental<br>_____ Initials _____ Date | | | | |
| POST-PARTUM<br>Screened by: _____Physician _____Nurse _____Other _____WIC _____Dental<br>_____ Initials _____ Date | | | | |
| Screened by: _____Physician _____Nurse _____Other _____WIC _____Dental<br>_____ Initials _____ Date | | | | |
| INJURY/ILLNESS<br>Screened by: _____Physician _____Nurse _____Other _____WIC _____Dental<br>_____ Initials _____ Date | | | | |
| Screened by: _____Physician _____Nurse _____Other _____WIC _____Dental<br>_____ Initials _____ Date | | | | |

| DATE | DOMESTIC VIOLENCE SCREENING NOTES |
|---|---|
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**INTERNATIONAL COMMUNITY HEALTH SERVICES**
**DOMESTIC VIOLENCE DOCUMENTATION FORM**

Patient Name:_____ Chart Number:_____

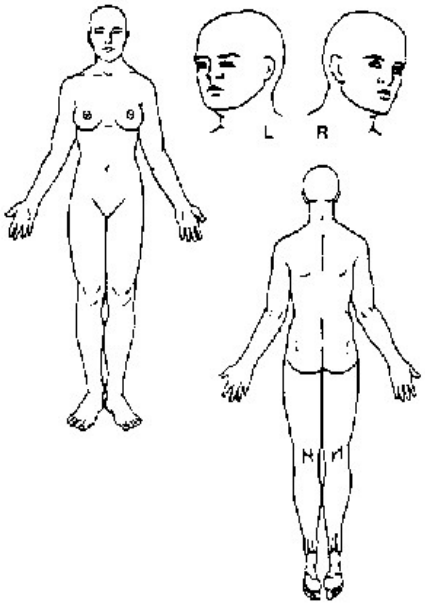
**WRITTEN DOCUMENTATON: Document domestic violence findings. Use the patient's own words and specific details of physical and psychological violence.**

| | |
|---|---|
| Documented by<br>_____Physician _____Initials<br>_____Nurse<br>_____Other _____Date<br><br>Reason for Visit:<br>_____Pregnancy Detection _____3rd Trimester<br>_____1st Trimester _____Post-Partum<br>_____2nd Trimester _____Injury/Illness<br><br>Photographs taken:<br>_____ Yes _____ No<br><br>Consent signed on photograph:<br>_____ Yes _____ No<br><br>Photographs attached:<br>_____ Yes _____ No | _____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>Provider Signature: _____ |

**INDICATE NUMBER OF INJURIES: Place a number in the box(es) to identify number of injury, type(s) and location(s).**

| | CONTUSIONS | ABRASIONS | LACERATIONS | BLEEDING | BURNS | DISCOLORATIONS | BONE FRACTURES | TENDERNESS | BITES |
|---|---|---|---|---|---|---|---|---|---|
| HEAD | | | | | | | | | |
| EARS | | | | | | | | | |
| NOSE | | | | | | | | | |
| CHEEKS | | | | | | | | | |
| MOUTH | | | | | | | | | |
| NECK | | | | | | | | | |
| SHOULDER | | | | | | | | | |
| ARMS | | | | | | | | | |
| HANDS | | | | | | | | | |
| CHEST | | | | | | | | | |
| BACK | | | | | | | | | |
| ABDOMEN | | | | | | | | | |
| GENITALS | | | | | | | | | |
| BUTTOCKS | | | | | | | | | |
| LEGS | | | | | | | | | |
| FEET | | | | | | | | | |

**INJURY LOCATION MAP: Indicate with an "x" where injury was observed.**



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**INTERNATIONAL COMMUNITY HEALTH SERVICES**
**DOMESTIC VIOLENCE DOCUMENTATION FORM**

**Staple sealed envelope(s) with photos below; marked on front "CONFIDENTIAL— DO NOT RELEASE".**
**Label each photo: Patient's name, date, location of injury, photographer's name & signature.**

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**International Community Health Services**
**DOMESTIC VIOLENCE ASSESSMENT FORM**

Patient Name: _____DOB: _____CHART #: _____

ICHS Staff: _____ Date: _____

This tool may be used as an assessment guide for safety planning.

**LETHALITY RISK**
**Guide the patient through the assessment questions. Pay attention to the patient's personal and cultural comfort with each subject area. Paraphrase questions when necessary. Use framing statements when appropriate and skip questions that you know for certain does not apply to the patient, or has already been answered in the initial screening. Each positive answer indicates a higher level of danger for the patient.**

**If Domestic Violence is revealed: Ask all questions**
**If Domestic Violence suspected: Ask only those marked with ***

| | | |
|---|---|---|
| **Control/Violence** | *Has your partner become more controlling lately? | _____ Yes _____ No |
| | *Does your partner control most of your daily activities?<br>(Examples: Does he dictate whom you can be friends with, how much money you can spend, or when you can use the car?) | _____ Yes _____ No |
| | *Has your partner become increasingly jealous or accuse you of infidelity? | _____ Yes _____ No |
| | *Has your partner ever beaten you when you were pregnant? | _____ Yes _____ No |
| | *Is your partner violent outside the home? | _____ Yes _____ No |
| | *Does your partner harm or mutilate family pets? | _____ Yes _____ No |
| **Severity Of Violence** | Has the physical violence become more severe over the past year? | _____ Yes _____ No |
| **Frequency Of Violence** | Has the physical violence occurred more than once over the past year? | _____ Yes _____ No |
| **Firearm** | Are there weapons in the home, especially guns? | _____ Yes _____ No |
| | *Has your partner threatened you with a weapon? | _____ Yes _____ No |
| | *Has the weapon ever been used in an attack on you? | _____ Yes _____ No |
| **Drugs/Alcohol** | Does your partner use drugs or alcohol? | _____ Yes _____ No |
| | Is your partner drunk every day or almost every day, or is a binge drinker? | _____ Yes _____ No |
| **Sexual Abuse** | *Has your partner ever forced you to have sex or engage in sexual acts when you did not want to? | _____ Yes _____ No |
| **Abuser's Access To The Victim** | If your partner is in jail, will he be released from jail soon?<br>Release date: _____ | _____ Yes _____ No |
| | Does your partner have a key to your place? | _____ Yes _____ No |
| | Are you planning to leave/divorce your partner? | _____ Yes _____ No |
| | Is your partner aware of your plans to get outside help? | _____ Yes _____ No |
| **Danger To Children** | Do you have children? | _____ Yes _____ No |
| | *Has your partner ever hurt your children? | _____ Yes _____ No |
| | Do the children see what is going on? | _____ Yes _____ No |
| | Has Child Protective Services been involved? | _____ Yes _____ No |
| **Homicide / Suicide** | *Do you think of suicide as a way out of the relationship? | _____ Yes _____ No |
| | Have you ever considered, threatened, or attempted suicide? | _____ Yes _____ No |

| | | |
|---|---|---|
| | Do you have a plan or method by which you would kill yourself or your partner? | _____ Yes _____ No |
| | *Has your partner ever tried to choke you? | _____ Yes _____ No |
| | *Do you believe your partner is capable of killing you? | _____ Yes _____ No |
| | *Has your partner ever threatened or tried to commit suicide? | _____ Yes _____ No |
| | *Has your partner threatened or tried to kill you or others close to you? | _____ Yes _____ No |
| **"Vulnerable Adult" Abuse** | Does the patient meet legal criteria for a "vulnerable adult?" (Any individual who is 60 years of age or older and has the functional, mental, or physical inability to care for her/himself, OR an adult who is developmentally disabled, and abused and neglected.) | _____ Yes _____ No |

**SUPPORT NETWORK ASSESSMENT: Assist the patient in completing the below. Legal action and strong social support enhances the patient's welfare and safety.**

**If Domestic Violence is revealed or patient answered "Yes" to any Lethality Risk questions, complete the below:**

| | | |
|---|---|---|
| **Legal Services** | List any valid court orders in effect | |
| | List accounts that the police has been involved | |
| | List any legal proceedings pending | |
| **Resources/ Strength** | List your social support in the local area (supportive friends/family) | |
| **Financial Resources** | List your financial and other resources. | |
| **Shelter** | List places (friends/family) where you can stay that abuser doesn't know | |

*This assessment is adapted from the Perinatal Partnership Against Domestic Violence Lethality Assessment Tool (Seattle, WA) Women in Safe Homes' Danger Assessment (Ketchikan, Alaska), YVFWC Community Health Services Department's Evaluation for Physical Abuse (Seattle, WA).*

Patient Name: _____CHART #: _____

ICHS Staff: _____ Date: _____

**Safety Planning helps domestic violence survivors strategize ways to be safer.**

**Each woman's domestic violence is unique and the materials presented may be adjusted to better accommodate each patient's situation, comfort level, and readiness to take action. The survivor is her own best expert.**

**Assist the patient in filling out the form. A copy of the completed form can be provided to the patient for reference. Make sure that it is safe to do so.**

## I. Safety Options

**Place an "X" next to each completed action.**

| | ACTIONS | X |
|---|---|---|
| **SOMEONE NO LONGER LIVING WITH ABUSER** | Get to safety/Go to hospital or motel for safety. | |
| | Make arrangements to pick up your belongings (if they remain w/ abuser). | |
| | Call the police. | |
| | Document threats. | |
| | Tell your neighbors what do to if they see the abuser nearby. | |
| | Develop a code system with neighbors/friends. | |
| | Establish a check-in system. | |
| | Pack a safety bag. | |
| | Change the locks. | |
| | Lock all windows. | |
| | Change your phone number. | |
| | Change the locks on the car. | |
| | If stay in house with abuser, search the house for weapons you do not know about. | |
| | Change your daily routine. | |
| | Change your transportation routes | |
| | Keep a copy of your Restraining Order anywhere you might need it. | |
| | Get/borrow a barking dog. | |
| **SOMEONE WHO IS STAYING** | Pack a safety bag with clothes and copies of important papers. | |
| | Contact friends the batterer does not know. | |
| | Established a code system with friends/neighbors. | |
| | Establish a check in system. | |
| | Put emergency phone numbers all over the house. | |
| | Teach your children what to do in an emergency. | |
| | Get extra house/car keys made and put them someplace accessible. | |
| | Call a local hotline or shelter program. | |
| | Program the phone to dial emergency numbers. | |
| | Plan where to go in a crisis. | |
| | Make sure there is gasoline in the car. | |
| | Get a cordless phone. | |

## II. Safety During a Violent Incident

The following steps may help the survivor prepare in advance for the possibility of future violence.

1. If I feel the abuser is about to be violent, I can try to move to _____ (Try to avoid the bathroom, garage, kitchen, and places near weapons or rooms without access to the front door.)

2. If it's not safe to stay, I will _____ (Practice how to get out safely. What doors, windows, elevators, stairwells, or fire escapes will you use?)

3. If I leave my home, I can go to _____, or _____ or _____. (Decide this even if you don't think there will be a next time.)

4. I can keep my bag/purse and car keys ready and keep it (place) _____ _____so I can leave quickly. (Keep a list of emergency numbers in your purse or wallet.)

5. Some important telephone numbers I need to know are:

   a. Police department (home):_____

   b. Police department (school):_____

   c. Police department (work):_____

   d. Work:_____

   e. Battered women's program:_____

   f. Shelter:_____

   g. County registry of Protection Order:_____

   h. Other:_____

6. I can tell _____and _____about my situation and ask them to call the police if they hear suspicious noises coming from my home.

7. I can use_____as my code word/phrase with my children or my friends so they can call for help.

8. I can teach my children some of these strategies and how to use the telephone to contact the police and the fire department.

9. I will remember that if I call 911 and leave the phone off the hook, the domestic violence incidence will be tape-recorded and an officer should respond to the scene.

10. Remember, as a domestic violence survivor, you know the abuser best. You know how to protect yourself and your children better than anyone else.

## III. Safety When Preparing to Leave

**Abused survivors frequently leave the residence they share with the abuser. Leaving must be done strategically in order to increase safety. Abusers often strike back when they believe that the survivor is leaving the relationship.**

1. I will check with _____and _____to see if I could stay with them in an emergency. (It is best if the abuser does not know them or where they live.)

2. I will memorize the 24-hour crisis line of the domestic violence agency closest to me. That number is _____. I can keep the number in my wallet along with other important phone numbers (see above suggestions) and change or phone card for phone calls with me at all times (if possible.)

3. I will leave money and an extra set of keys with _____so I can leave quickly.

4. I can keep copies of important documents or keys and some extra clothes with _____

   _____or _____

5. If I own a car, I can try to make sure that I keep a set of car keys with _____

   _____ or _____and gas in the car.

6. I can open my own bank account by _____(date). (Preferably open an account in a separate bank from the one that you and the abuser use jointly.)

7. I can also begin to _____as a way of increasing my safety.

8. Other things I can do to increase my safety include:_____

   _____

   _____

9. I can sit down and review my safety plan every _____so that I know the

   safest way to leave my home. _____(Domestic violence advocate or friend) has agreed to help me review this plan.

10. I can rehearse my escape plan and, as appropriate, practice it with my children.

11. I can keep the items concerning me in one location. If I have to leave in a hurry, I can grab those items quickly.

12. What I need to take when I leave might include:

- ☐ Identification for myself
- ☐ Driver's license
- ☐ My birth certificate
- ☐ My children's birth certificates
- ☐ Money & small saleable objects
- ☐ Lease, rental agreement, house deed, mortgage payment book
- ☐ Bank books
- ☐ Check books
- ☐ Credit cards
- ☐ Insurance papers
- ☐ Keys-house/car/office
- ☐ Medications for me & my children
- ☐ Rent & utility receipts
- ☐ Important phone numbers
- ☐ Vehicle license plate numbers
- ☐ Address book
- ☐ Medical records—for all family members
- ☐ Social security cards
- ☐ Welfare identification
- ☐ School records
- ☐ Work permits
- ☐ Green card
- ☐ Passport(s)
- ☐ Marriage license
- ☐ Divorce papers
- ☐ Jewelry
- ☐ Children's favorite toys &/or blanket
- ☐ Items of special sentimental value
- ☐ Pictures
- ☐ Extra clothing

## IV. Safety in the Home

**There are things that a domestic abuse survivor can do to increase safety in the home. It may be impossible to do everything at once, but safety measures can be added step by step.**

1. I can find a safe place to keep this plan.

2. If there are weapons (guns, knives, etc.) in my house, I can try to remember:

   a. To encourage the abuser to get rid of the gun if it is safe for me to do so.

   b. To stay out of rooms where weapons are kept, especially during an explosive situation.

   c. To move the knives out of their usual location so that my partner will have trouble finding a knife quickly.

   d. That almost anything can be used as a weapon.

   e. That cleaning a gun or knife in front of me is a threat and may imply that my partner is capable of taking my life or hurting my children.

3. I can teach my children to _____

   _____when I am not available.

4. If the abuser no longer lives with me, I will tell people who take care of my children which people have permission to pick up my children and that the abuser is not permitted to do so. The people I will inform about pick-up permissions include:

   a. (School)_____

   b. (Day care staff)_____

   c. (Babysitter)_____

   d. (Other)_____

5. If the abuser destroys my Protective Order, I can get another copy from the _____

   _____ District Court.

6. If the abuser no longer lives with me, I can tell my neighbors and ask them to call 911 if he/she is seen near my home.

7. If the abuser no longer lives with me, I can take action to ensure my safety and my children's safety in my own home.

8. If the abuser no longer lives with me, safety measures I can take include:

   a. Change the locks on my doors and secure locks on my windows as soon as possible.

   b. Replace wooden doors with steel/metal doors.

   c. Install security systems, including additional locks, window bars, poles to wedge against doors, an electronic alarm system, etc.

   d. Purchase rope ladders to be used for escape from second floor windows.

   e. Install smoke detectors and purchase fire extinguishers for each floor in my home.

   f. Install an outside lighting system that lights up when a person is coming close to my home.

9. If the abuser no longer lives with me, I can tell school and/or child care who has permission to pick up my children.

10. I can teach my children how to use the telephone to make a collect call to me and to

    _____(friend, other) in the event that the abuser abducts them.

## V. Safety With a Protection Order (or other Court Orders)

**Many domestic violence abusers obey protection orders, but a survivor can never be sure which abuser will obey and which will violate protection orders. The survivor might need to ask the police and the courts to enforce your protection order.**

1. I will keep my Protection Order_____ (location). (Always keep it on or near your person. If you change purses, that is the first thing that should go in.)

2. I will give my protection order to the police departments in the community where I work, in those communities where I usually visit family or friends, and in the community where I live.

3. There should be a county registry of protection orders that all police departments can call to confirm the validity of a protection order. I can check to make sure that my order is in the registry. The telephone number for the county registry (Sheriff's

   Office) is _____.

4. For further safety, if I often visit other counties in Washington, I might file my protection order with the court in those counties. I will register my protection order in the following countries:

   _____

   _____

5. I can call the local domestic violence program(s)_____ if I have questions or if I have some problem with my protection order.

6. If the abuser violates the order, I will call the police and report a violation, contact my attorney, call my domestic violence advocate, and/or advise the court of the violation.

7. If the police do not help, I can contact my advocate or attorney and will file a complaint with

   the _____

   _____

8. I will tell_____ and _____and _____that I have a Protection Order in effect.

9. If the abuser destroys my protection order, I can get another copy from the Superior Court located at _____.

10. Remember that in the State of Washington, if your partner assaults you when you have a valid Protection Order, your partner can be charged with a felony.

## VI. Safety on the Job and in Public

**Each domestic abuse survivor must decide if and when she will tell others, and acknowledge that there might be continued risk. A survivor should consider carefully which people to invite to help secure safety. Friends, family, and co-workers can help to protect.**

1. I can inform my boss and _____ at work of my situation, if I feel safe with them.

2. I can use voicemail or ask _____ to help me screen my calls at work.

3. When leaving work, I can _____ to help keep myself safe.

4. If problems occur while I am driving home, I can _____

   _____

5. If I ride the bus and see the abuser, I can _____

6. I can use different grocery stores and shopping malls to conduct my business and shop at hours that are different than those when residing with the abuser.

7. I can also _____

   _____

   _____

## VII. Safety and Emotional Health

**The experience of being abused and verbally degraded is usually exhausting and emotionally draining. The process of building a new life for the survivor takes much courage and incredible energy.**

1. When I have to talk to the abuser, I can _____ to keep myself safe and take care of myself.

2. When I feel down, I can _____

   _____

3. I can read _____ to help me feel stronger.

4. I can call _____ and _____

   and _____ for support.

5. I can tell myself – "_____

_____" whenever I feel others are trying to control or abuse me.

6. Other things I can do to help me feel stronger are _____

_____

_____

7. I can call a local agency or other support system if I need immediate help. That number is_____

8. I know that community support groups are available to help me take care of myself.

9. I can attend workshops and support groups at the domestic violence program or _____ to gain support and strengthen my relationships with other people.

## VIII. Safety and Drug/Alcohol Consumption

**The use of alcohol or other drugs can reduce a survivor's awareness and ability to act quickly to protect her from the abuser. The use of alcohol or other drugs by the abuser may give him/her an excuse to use violence. Therefore, in the context of drugs or alcohol consumption, a survivor needs to make specific safety plans.**

1. I know that it is easier to keep safe when I am sober.
2. I know that alcohol and drug use can impair my judgment and make it harder for me to choose safe options and access services.
3. I can call _____ for support when I feel like drinking or drugging to cope. That number is_____.
4. I can call _____ when I need information, referrals or support. That number is_____.
5. If I am going to consume alcohol or other drugs, I can do so in a safe place and with people who understand the risk of violence and are committed to my safety. I can also _____

_____

or

_____ or

_____

6. If my partner is consuming, I can _____ or

_____

_____

7. To protect my children, I can _____

_____

_____

This Safety Plan is adapted from Moses Lake Community Health Center's Personalized Safety Plan (Moses Lake, WA), New Beginnings (Seattle, WA), Perinatal Partnership Against Domestic Violence Safety Plan (Seattle, WA), Providence Health Systems Safety Plans (Seattle, WA), AWAKE Personalized Safety Plan (Boston, MA.), Beth Israel Deaconess Medical Center (Boston, MA), RESPOND Inc.'s Training Manual (Somerville, MA).

## Safety While Sharing a Home with Your Partner

If you are living with the person who is hurting you, here are some things you can do to ensure your and your children's safety.

1. **Keep this card in a safe place** where your husband can't find, but you can get to for review .
2. **Set money aside for you and your children.** Keep it in a safe place where your husband can not find it.
3. **Decide where you might go if you leave home.** Friends your partner doesn't know? Shelter? Motel?
4. **Leave extra money, clothes, copies, copy of car keys, and important documents with a trusted friend/relative—** birth certificates, children's school/medical records, welfare ID, immigration cards/papers, social security card, housing payment and bank books, insurance papers, medicine, prescriptions, etc.
5. **Keep change for pay phones and gas in your car at all times.**
6. **Memorize important phone numbers and have them programmed into your phone** of friends,/relatives to call in an emergency. Teach your children these numbers, and when and how to dial 911.
7. **Rehearse your escape plan until you know it by heart.** What doors/windows/elevators/stairwells will you use to get out safely?
8. **Use an emergency code word/phrase with your children and your friends so they can call for help.** Tell a trusted neighbor about your situation and ask them to call the police if they hear suspicious noises coming from your home.
9. **When your partner becomes violent—** move to a safer location. Avoid bathroom, garage, kitchen, places near weapons, or rooms without an outdoor exit. Call 911 and leave the phone off the hook. The incident will be tape-recorded and the police will come.

## Safety After You Have Left Your Partner

Once you no longer live with the abuser, here are some things you can do to enhance your and your children's safety.

1. **DO NOT attempt to pick up your belongings if they remain with your former partner** .
2. **Obtain a restraining order.** Keep it near you at all times, and make sure friends and neighbors have copies to show the police. Document threats for police reporting.
3. **Inform your neighbors that your former partner is not welcome on your premises.** Ask them to call the police if they see that person nearby or watching your home.
4. **Change the locks** to your home/car/garage (if you're still in the home and your partner was the one who left).
5. **Lock all windows.**
6. **Install as many security features as possible to your home.** These might include metal doors and gates, security alarm systems, smoke detectors, outside lights, get a barking dog.
7. **Change your phone number.**
8. **Change your daily routine and transportation routes.** Avoid the stores, banks, businesses, and bus routes you used when you were living with your partner.

ICHS and DOH have translations of these cards in Chinese and Vietnamese.

You can contact the following numbers for help:

**Emergency**

- Police/Ambulance: 911

**24-Hour Help and Shelter**

- WA State Domestic Violence Hotline: 1-800-562-6025
- Abused Deaf Women's Advocacy Services: 206-236-3134
- Catherine Booth House: 206-324-4943
- Domestic Violence Abuse Women's Network:
  24-hour help: 206-656-7867
  Shelter: 206-622-1881
- Eastside Domestic Violence: 425-746-1940
- New Beginnings: 206-522-9472

**Agencies with Bilingual Staff**

- Asian Pacific Islander Women & Family Safety Center (languages: Tagalog, Korean, Samoan): 206-467-9976
- Chaya (languages: Hindi, Bengali, Gujarati, Kannada, Malayalam, Marathi, Punjabi, Tamil, Telegu): 1-877-922-4292
- Chinese Information Service Center (languages: Mandarin, Cantonese): 206-624-4062
- Korean Community Counseling Center (language: Korean) 206-784-5691
- Refugee Women's Alliance (languages: Cantonese, Mandarin, Cambodian, Ukrainian, Romanian, Russian, Ethiopian, Hmong, Laotian, Thai, Somali, Tagalog, Vietnamese): 206-721-3846

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**CONFIDENTIAL**

**International Community Health Services**
**Pregnancy Test**

Date: ____/ ____/ ____ MR#: _____

Name: _____ DOB: _____ Language: _____

Address: _____ Phone: _____

Monthly Family Income: _____ Family Size: _____

Age: _____ G: _____ P: _____ LC: _____ LMP: ____/ ____/ ____

Pain or bleeding since LMP? _____

Contraceptive Method: Before Visit: ☐☐ After Visit: ☐☐

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 01 | Sterilization | 04 | Diaphragm/Cap | 07 | Spermicide | 10 | None |
| 02 | Oral contraceptive | 05 | Foam & Condom | 08 | Natural/Calendar | 11 | Norplant |
| 03 | IUD | 06 | Condom | 09 | Other _____ | 12 | Injection |

If no contraceptive method at end of visit, give a reason:

☐ Pregnant ☐ Planned ☐ Unplanned ☐ Not sexually active
☐ Other medical Plan ☐ Infertility ☐ Seeking pregnancy
☐ Relying on partner's method

UCG:

☐ Positive ☐ Negative

Patient's plans for pregnancy:

☐ Continue ☐ Terminate ☐ Not sure

Counseling/Education Provided

☐ Contraceptive ☐ Substance abuse ☐ Pregnancy ☐ Preconceptional
☐ Tobacco ☐ STD/HIV prevention ☐ Nutrition ☐ Crisis
☐ Others _____ ☐ DV screening (see below)*

Referrals:

☐ Family Planning ____/ ____/ ____ with _____
☐ Pregnancy confirmation ____/ ____/ ____ with _____
☐ Termination ____/ ____/ ____ with _____
☐ Medical appointment ____/ ____/ ____ with _____
☐ OB coordinator ____/ ____/ ____ with _____
☐ Financial screener ____/ ____/ ____ with _____
☐ Other _____ ____/ ____/ ____ with _____

X _____

*Domestic violence is common in pregnant women's lives. ICHS now asks all perinatal patients about DV. In the past year have you…
Been hit/slapped/kicked/pushed/physically hurt? ___Yes ___ No
Experienced uncomfortable touching/forced sexual contact? ___ Yes ___ No

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International Community Health Services

☐ ID Clinic – 720 8th Ave S, Suite 100, Seattle, WA 98104 Phone: 206-461-3235

☐ Holly Park Clinic – 7116 Martin Luther King Jr. Way S, Seattle, WA 98118 Phone: 206-461-4948

Name:_____ DOB: _____ Phone: _____

MR# _____ LMP: ____/ ____/ ____ Urine Pregnancy Test: ☐ Positive ☐ Negative

# PRENATAL RECORD

| DATE | AGE | RACE/ETHNICITY | RELIGION | OCCUPATION | YRS. ED. | MARITAL STATUS | FATHER OF BABY | FATHER'S WORK PHONE |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

| PHONE-HOME | PHONE-WORK | ADDRESS | REFERRAL-SOURCE | MOTHER'S PRIMARY CARE PROVIDER |
|---|---|---|---|---|
| | | | | |

## GYNECOLOGICAL HISTORY

| MENARCHE YRS | INTERVAL | ☐ REGULAR ☐ IRREGULAR | DURATION DAYS |
|---|---|---|---|
| | | | |

✓ IF NEGATIVE-DESCRIBE POSITIVE HISTORY

| | |
|---|---|
| | PAP HISTORY |
| | INFERTILITY/ART |
| | GYN DISORDER |
| | GYN SURGERY |
| | DES EXPOSURE |
| | PRIOR CONTRACEPTION |
| | BCP W/IN 90 DAYS CONCEP |
| | BREASTS |
| | OTHER GYN HX |
| | GONORRHEA |
| | SYPHILIS |
| | CHLAMYDIA |
| | HERPES-SELF/PARTNER |
| | OTHER STD/HIV |
| | |

## MEDICAL HISTORY

✓ IF NEGATIVE-DESCRIBE POSITIVE HISTORY

| | |
|---|---|
| | HEENT |

## MEDICAL HISTORY – CONTINUED

| | |
|---|---|
| | CARDIOVASCULAR |
| | RESPIRATORY/TB/ASTHMA |
| | GI/HEPATITIS |
| | GU |
| | METABOLIC/THYROID |
| | NEURO |
| | COAGULATION DISCORDERS |
| | PSYCH/DEPRESSION |
| | MUSCULOSKELETAL |
| | SKIN DISORDERS |
| | OTHER DISEASE/DX |
| | OPERATIONS |
| | TRANSFUSIONS |
| | ALLERGIES/LATEX/IODINE |
| | SEXUAL ABUSE/VIOLENCE |

## FAMILY HISTORY - NOTE IF FATHER OF BABY

| | |
|---|---|
| | DIABETES |
| | HYPERTENSION |
| | TWINS |
| | CONGENITAL ANOM |
| | OTHER FAMILY HX |

## PREVIOUS PREGNANCIES

| NO. | DATE | LENGTH (WKS) | LABOR (HRS) | TYPE DELIVERY | ANES. | SEX | WEIGHT | WHERE DELIVERED | COMPLICATIONS-AP, IP, PP, NEONATAL | OUTCOME/ NAME |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

## PRESENT PREGNANCY HISTORY

| LMP ☐ NORM ☐ ABNORM | LNMP | EDD | + PG TEST | TYPE | DATE |
|---|---|---|---|---|---|
| | | | | | |

| PLANNED PREGNANCY/OK? | FATHER SUPPORTIVE? |
|---|---|
| | |

✓ IF NEGATIVE-DESCRIBE POSITIVE HISTORY

| | |
|---|---|
| | NAUSEA/VOMITING |
| | BLEEDING |
| | URINARY SX |
| | VAGINAL DISCHARGE |
| | INFECTION |
| | FEVER/RASH |
| | TOBACCO USE/2ND HAND SMOKE |
| | ETOH |
| | DRUGS |
| | FOLIC ACID PRIOR TO PG |
| | PHYSICAL/SEXUAL ABUSE/DV |

PATIENT NO.

PATIENT NAME

D.O.B.

## PHYSICAL EXAMINATION — DATE

✓ IF NEGATIVE-DESCRIBE POSITIVE FINDINGS

| | |
|---|---|
| | HEIGHT |
| | WEIGHT |
| | B.P. |
| | HEENT |
| | NECK |
| | LUNGS |
| | BREASTS |
| | HEART |
| | ABDOMEN |
| | NEURO |
| | EXTREMITIES/SKIN |
| | TEETH/ORAL HEALTH |

## PELVIC EXAMINATION — DATE

| | |
|---|---|
| | EXT. GENITALIA |
| | VAGINA/CERVIX |
| | UTERUS-SIZE |
| | ADNEXA |
| | CLINICAL PELVIMETRY |
| | HEMORRHOIDS |

PROVIDER SIGNATURE

| PREGNANCY DATING | DATE | WEEKS | EDD/RANGE |
|---|---|---|---|
| LMP | | | |
| LNMP | | | |
| OVU/CONCEP | | | |
| FIRST EXAM | | | |
| FHT DOPPLER | | | |
| FM | | | |
| ULTRASOUND | | | |
| ULTRASOUND | | | |
| ULTRASOUND | | | |
| | | | |
| | | | |
| | | | |

| DATE | PROBLEMS AND RISK FACTORS |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## ANTICIPATORY GUIDANCE

| FIRST TRIMESTER | SECOND TRIMESTER | THIRD TRIMESTER |
|---|---|---|
| CLINIC PROCEDURES/OUTLINE PRENATAL CARE | FETAL DEVELOPMENT/QUICKENING | DISCOMFORTS/RELIEF MEASURES |
| HIV COUNSELING/TESTING | FAMILY/FATHER/SIBLINGS | WARNING SIGNS |
| CF SCREENING | HOSPITAL PRE-ADMISSION/TOUR? | FETAL ACTIVITY MONITORING |
| NUTRITION | BENIFITS OF BREASTFEEDING | LABOR SIGNS: WHEN AND HOW TO CALL |
| VITAMINS/MINERALS | EXERCISES/BODY MECHANICS | TRAVEL RESTRICTIONS |
| DENTAL/VISION CARE | WARNING SIGNS: SROM, BLEEDING, PRE-TERM LABOR | LABOR & DELIVERY ROUTINE |
| WEIGHT GAIN | BABY'S CARE PROVIDER _____ | ELECTRONIC FETAL MONITORING |
| SEAT BELTS | CIRCUMCISION | ANESTHESIA/ANALGESIA |
| EXERCISE | BROCHURES | EPISIOTOMY/PERINEAL INTEGRITY |
| PRENATAL DIAGNOSIS/GENETICS REFERRAL | PRENATAL CLASSES | LABOR & DELIVERY COMPLICATIONS/OPERATIVE DELIVERY/VBAC |
| HAZARDS: HOT TUBS/SAUNA, CATS | SUPPORT PERSON _____ | BREAST CARE/LACTATION SUPPORT/REFERRAL |
| LISTERIA (RAW MEAT, SLICED DELI MEAT, UNPASTURIZED DAIRY, FRESH CHEESE) | BIRTH PLANS/OPTIONS | CAR SEAT |
| DISCOMFORTS/RELIEF MEASURES | SEXUALITY | INFANT SLEEP POSITION |
| WARNING SIGNS: BLEEDING, CRAMPS, ABDOMINAL PAINS, DYSURIA, ETC. | DOMESTIC VIOLENCE | DISCUSS POST-TERM MANAGEMENT |
| BROCHURES | ALCOHOL/DRUGS/TOBACCO | EARLY DISCHARGE/HELP AT HOME |
| DOMESTIC VIOLENCE | | DOMESTIC VIOLENCE |
| ALCOHOL/DRUGS/TOBACCO | | ALCOHOL/DRUGS/TOBACCO |

| DATE | MEDICATIONS |
|---|---|
| | PRENATAL VITAMINS? |
| | RHOGAM |
| | |
| | |

HERBS/VITAMINS PT IS TAKING:

DRUG ALLERGIES/REACTIONS ☐ NKA

### POST PARTUM ISUES

- ☐ CONTRACEPTION: _____
- ☐ STERILIZATION - DATE TUBAL FORM SIGNED: _____
- ☐ EMERGENCY CONTRACEPTION PILLS DISPENSED
- ☐ DEPRESSION/PP MOOD DISORDER ASSESSMENT
- ☐ ALCOHOL/DRUGS/TOBACCO
- ☐ SECOND HAND SMOKE

PATIENT NAME

### PROGRESS NOTES

*(Continued on page 4)*

CONFIDENTIAL International Community Health Services

**FAMILY PLANNING ANNUAL EXAM**

Postpartum Visit at 8 weeks

Date of visit: ____/ ____/ ____ Wt _____ BP _____ P _____

Age: _____ G: _____ P: _____ LC: _____ SAb : _____ TOP: _____

LMP: ____/____/____ Normal? _____ PMP ____/____/____

Cycle: _____d. Regular? _____ Mensus dur. _____d.

Flow: _____ Cramps: _____

Abnl Bleeding? _____

Discharge: _____

If pp exam, del. Info: _____

Other problems? _____

_____

Hx abnl Pap? _____

Last Pap? ____/____/____ Class: _____ DES expos.? _____

Sexually active? _____

Contraception? _____

_____

Smoke: _____ EtOH: _____ Drugs: _____

Breast exam: Knows? _____ Performs? _____

PMH: _____

_____

Meds: _____

Skin _____

HEENT _____

Thyroid _____

Breasts _____

Axilae _____

Lungs _____

CV _____

Abdomen _____

Ext. genit. _____

Vagina _____

Cervix _____

Uterus _____

Adnexas _____

Rectal _____

Extrem. _____

**Counseling:**

Contraception NFP sterilization
Infertility tobacco/substance abuse
Pregnancy preconceptional (Hep B, thal)
Abstinence STDs HIV nutrition
PMS ESE Mamogr. emergency contraception other: _____

Assessment:

Plan: ☐ Lab (circle): Pap/ Hct / CBC / Rubella / HbsAg / CT / UCG / Other (_____) UA
Wet Mount

☐ OB chart & delivery info reviewed (for pp exams)

☐ PT counseled re: contraceptive options, risks, benefits, use.
Pt chooses contraceptive method=

☐ RTC _____

*Domestic violence is common in pregnant women's lives. ICHS now asks all perinatal patients about DV. In the past year have you…

Been hit/slapped/kicked/pushed/physically hurt? ___Yes ___ No

Experienced uncomfortable touching/forced sexual contact? ___ Yes ___ No

X _____

(Rev. 10/95)

# Appendix F

## Resources

# Washington State Resources

### Washington State Domestic Hotline

General information and referral for patients, perpetrators, general public, and professionals.

**1-800-562-6025 V/TTY**

http://www.wavanet.org/

### Alcohol Drug Help Line for Washington State

Resources and referral for drug and alcohol issues.

**1-800-562-1240 TTY**

### Washington State Coalition Against Domestic Violence

General information, resources, and training.

**206-389-2515 and 206-389-2900 TTY**

http://www.wscadv.org/

### Washington State Department of Health

Training Opportunities, fact sheet, and information.

**253-395-6739**

http://www.doh.wa.gov/cfh/mch/Women.htm

### Physicians Insurance

Prenatal Record Forms

**1-800-962-1399**

http://www.phyins.org/

# National Resources

### Family Violence Prevention Fund

For information, training materials, community organizing, brochures, posters, etc.

**415-252-8900**

www:fvpf.org

### Maternal Child Health Bureau

http://www.mchb.hrsa.gov//dpswh

### Domestic Violence Clearing House

www.nrcdv.org


**Community and Family Health**


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